	A64
	Physician
	/Medical
2	Examiner

The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, certificate

1 - For State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 2:40 p M Richard William Werbisky February 18, 2006 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Anne Arundel 209 Drum Avenue North Pasadena 8. Date of Birth (Month, Day, Year)
Oct. 22, 1 Birthplace (State or Foreign Country) If Under 24 Hrs. 7. Age (In yrs. last birthday) If Under 1 Year 5. Social Security Number **Funeral** Days 1**⊠**M 2□ F 72 1933 Director 150-24-2132 IJ Usual Residence of Decedent 10d. Inside City Limits within 72 hours after death with the Maryland 10c. City, Town or Location 10b. County 10a State ir than "natural", or Items 23a or 28a-f show the Medical Examinar must be notified at 1 ☐ Yes 2 No MD Anne Arundel Pasadena Direct 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 209 Drum Avenue North <u>USA</u> 21122 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?
1 XYes 2 □ No WW 14. Race - American Indian, Black, White, etc. 1 Never Married 2 X Married WWII 10 White 1 ☐ Yes 2 X No Specify: Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within: Department of health and Mental Hygiene. Important: If tem 27 is marked other than in eny injury or other treumatic event, tra Musting. Riegel Paper Mill Elementary/Secondary (0-12) College (1-4or 5+) Quality Assurance 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Sophie Wigranowsky William Werbisky 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 209 Drum Avenue North, Pasadena, MD Eleanor Bunko/Wife Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Feb. 22, 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State St. Johns Cemetery Alpha, NJ 2006 4 ☐ Donation 5 ☐ Other (Specify) Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. ritchie Hwy, Severna Park, MD 21146 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Small Physician disease or condition resulting in death) /Medical Examiner as Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) the attending physician and thed for use as the burial-translt that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 4 Pregnant at time of death 5 ☐ Other (specify) signed by the a d be detached for 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No cate has been signated to page 2 should to 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No Yes or Attending Physician: To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director. 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Certification: To Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home Residence 6 Other (Specify) 1 TYes TNO 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27 Manner of Death 5 Pending Injury Natural Accident 1 ☐ Yes 2 ☐ No investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Madical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier arond all 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Aquahart Rd. Glea Burnee UND 21061 Mayer Gorbetz

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

FEB 22

2006

32. R gistrar's Signature

		1	For State	State of Maryland		rtment of Hotificate of E			giene Reg. No.	07502	
	3	0 E	1. Decedent's Name (First, Middle, L	ast)				2. Date of Dea	ath	3. Time of Death	
	Physicia	an	Howard	Oakley	Ī	Wood		Month Februar		9:25 p	М
	/Medic Examin	Ca.	4a. Facility Name (If not institution, g			4b. City, Town, or	Location of Death		4c. County o	f Death	
	- Zamia	9	Crofton Convale	scent Center		Crofton				Arundel	
9	Funeral Director		5. Social Security Number 6. 552-09-6948	Sex 1X M 2 F 7. Age (In yrs. las	t birthday) Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Birt (Month, Da June 2	h y, Year) 4, 1918	9. Birthplace (State or Forei Country) England	ign
	D .	-	Usual Residence of Decedent  10a, State 10b, County	10c. City,	Town or Lo	cation				10d. Inside City Limi	its
	anyla shov	7				55(15)1				1 ☐ Yes 2 📆 🛪	
	28a-f	ecto	MD Anne A	rundel Cro	ofton	10f. Zip Code			10g. Citizen of W	hat Country?	
	with	D.	2131 Davidsonvi	lla Paad		2111	/1		USA		
	res 23	era	11. Marital Status	12. Was Decedent Ever in U.S.	13. V	Was Decedent of Hi f Yes, specify Cuba		ecify Yes or No		- American Indian,	
36	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If Item 27 is marked other then "natural", or Items 23a or 28a-f show or other treumatic event, the Medical Examiner must be notified at	by Funeral Director	1 Never Married 2 Married 3 Widowed 4 Tovorced	Armed Forces? 1XXves 2 □ No If Yes, Give Year or Dates: WWII		fYes, specify Cuba I⊡Yes 2 <b>XX</b> No	n, Mexican, Риепо Specify:	Hican, etc.)	Specify:	White, etc. White	
21215-0036	2 hou		15. Decedent's			dent's Usual Occupa		ana	16b. Kind of Bus	siness/industry	
212	hin 73	ple	(Specify only highest of Elementary/Secondary (0-12)	Coffege (1-4or 5+)	life. L	kind of work done a DO NOT use retired,	)	,,,,,g			
21	e filed within all Hygiene. I other then "	Completed			Repre	sentative			Building		
멀	be file ital Hy id oth	Be (	17. Father's Name (First, Middle, La	st)					Maiden Sumame	o)	
Maryland	2 should be and Mental Is marked of reumatic ev	2	Joseph Wood				Anne Oa		O: T	2	
lar	2 sh and Is m	. 3	19a. Informant's Name/Relationship			ng Address (Street a				state, ZIP Code)	
6	of Health Item 27	(8-	Nathaniel Wood  20a. Method of Disposition			Eton Way		Date		City or Town, State	
0	ges it of h		1 Burial 2XXCremation 3	☐Removal from State cen	netery, cren	natory or other plac	i	2006			
Baltimore,	it. Pa rtmer rtant njury		4 □ Donation 5 □ Other (Spe 21. Signature of Funeral Service Lice			ematory  2. Name and Addres		-2006	Baltimo	re, MD	-
Bal	permit. Pages 1 Department of H Important: If Ite any Injury or of once.		Howah	~		Hardesty 12 Ridge	Funeral 1y Avenu	e, Anna	polis, M		
			23a. art 1. Enter the disease, or co shock, or hear failule. List or	inplications that caused the death.	Do not ent	er the mode of dyin	g, such as cardiac	or respiratory a	rrest,	Approximate Interval Between Onset and Death	
	Physician		fmm iat a Cause ( inal/ dise se or condition	- Carlia	A	melloni	α				
	/Medical Examiner		resulting in death)	Due to (or as a conseque	nce of):	1					
	LXammer	Ļ	Sequentially list conditions,	b	nce of):						
	ed sit	Examine	if any, feading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseque	1100 017.						
	be executed sician and burial-transit	xan	that initiated events resulting in death) Last	c Due to (or as a conseque	nce of):						
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687	ficate physics to the	edic	100								
.O. Box	The law requires that the death certificate be executed the has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. ff yes, outcome of pregnant 1 ☐ Live birth 2 ☐ Fetal of 4 ☐ Pregnant at time of dea 9 ☐ Unknown	eath 3	Ectopic pregnancy Other (specify)			23d. Date Mor	e of delivery hth Day Year	
<u>α</u>	res that ligned by	by	Part fl. Other significant condition	contributing to death but not result	ing in the u	inderlying cause giv	en in Part I.			ibute to the cause of death?	
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Sec.	e law has t	npi	- Jall	e 10 juriue	Λ	4	. 1. 1	auto	psy p	rior to completion of cause leath?	of
a F			Olcl	Cerelno Vesci	Na	Acen		1 ☐ Yes		Yes 2 No	
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ot	Phys rthis raldi	. To	1 Yes 2 No 27. Manne of Death		R/Outpatier 28b. Time o				how injury occurr		
on	iding I th. : After funer	Ş	Natural 5 Pending 2 Accident investiga		Injury		k? Yes 2 □No				
Division	or Attendi after death Director: A in by the f	Certification:	3 Suicide 6 Could no 4 Homicide determin		ne, farm, st	reet, factory, office			(Street and Number wn, State)	er or Rural Route Number,	
_	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certifica completely filled in by the funeral director.	edical C	29a. Certifier (Check only one)  29a. Certifying (Check only 2 Medical E	Physician: To the best of my know kaminer: On the basis of examination and manner stated.	ledge, deat on and/or in	th occurred at the tire	me, date and place opinion, death occu	, and due to the rred at the time	cause(s) and ma date and place, a	nner as stated. and due to the cause(s)	
	o the ithin ; o the omple	Mec	29b. Signature and title of certifier	and marrier states.		29c. Licens	se number		29d. Date signed	(Month, Day, Year)	
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			30. Name and address of person w	ho completed cause of death (ftem	23a) (Tvoa	Print)	11000		~ ~ ~ ~		
			Aditio Cho	oram.D. Lon	SRI	dalles.	Auc. #23	31 Ann	radis	10415. DIN,	
Ŷ.	St Regist	ate	31. Date filed (Month, Day, Year)	2006 32. Phylistrar's Signatu	JIT BY	book					
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		For State Registrar	state of Ma	ıryland	-	artmen rtificate			nd M		iene	)6 (	7503
Physicia	ın	1. Decedent's Name (First, Middle, Last)	1man V	OLINIC	TD					2. Date of Deat Month Februar		2 X 84 F	3. Time of Death
/Medic Examine	al	James Til  4a. Facility Name (If not institution, give stre  20013 Tillman Avenu	et and number)	OUNG,	JK.	4b. City, Hage		Location of		rebruar	4c. Cou	nty of Death	1 3130 β.™ n
Funeral Director		220-20-3492	2□ F 7. Age	(In yrs. las		If Under Months	1 Year Days	If Under 2	4 Hrs. Min.	8. Date of Birth (Month, Pay, Jan. 12	Year) 1932	9. Birthr Cour Mary	place (State or Foreign ntry) y Land
Maryland -1 show	tor	Usual Residence of Decedent  10a. State 10b. County  Maryland Washingtor	ı		Town or Lo								10d. Inside City Limits 1 ☐ Yes 2 No
h with the	Funerai Director	10e. Street and Number 20013 Tillman Avenu	ie			10f. Zip	Code 2174	2		1	0g. Citizen	of What Cour	ntry?
OSC ors or	þ	11. Marital Status 12.  1 Never Married 2 Married 3 🗷 Widowed 4 Divorced	Was Decedent E Armed Forces? 1 ⊠Yes 2 □ N If Yes, Give Year or Dates:	963 <u>-</u> 1968	13.	Was Deced f Yes, spec 1 Pes 2		spanic Origi n, Mexican, Specify:	in? (Spe Puerto P	cify Yes or No- Rican, etc.)		Race - Americ Black, White, ecify: wh:	etc.
21215-0 ad within 72 ho gjene. er than "natur the Medical	Completed	15. Decedent's Educati (Specify only highest grade of Elementary/Secondary (0-12)	on ompleted) College (1-4or 5		16a. Dece (Give life.	kind of woi DO NOT us	rk done d se retired)	ition luring most o	of workin	ng		f Business/In	
and 21 ibe filed w ntal Hygier ad other th	Be	0-12  17. Father's Name (First, Middle, Last)  James Tillm	2			cutt	er	18. Mother		(First, Middle, M	faiden Sun	name)	acturer
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Baltimore, sermit. Pages 1 a Department of Hec mportent: If Item nny injury or othe		20a. Method of Disposition 1 ⊠ Burial 2 □ Cremation 3 □ Rem 1 4 □ Donation 5 □ Other (Specify)	oval from State	cen	ce of Dispo netery, crei or Cei	natory or o	ther place		Febr	uary		on - City or To manton	own, State , Maryland
Balt permit. Depart Import any inj		21. Signature of Funeral Service Licensee	m	(	1905			s of Facility		innich i			e ryland 2174
PV60, sate be executed  Examiner  Physician and  the burial-transit  The burial-transi	icai Examiner	23a. Part1. Enter the disease, or comiticat shock, or heart failure. List only one of immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, and any that interest of the cause (Disease or injury that initiated events resulting in death) Last  d	Due to (or as a	e. 	nce of):	ell		w	19	Four	vee	_	Approximate Interval Between Onset and Death
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To the within To the compact c	Me	29b. Signature and title of centifier	uuk	da	~ M	290	License	number (64)	13	29	od. Date sig	ned (Month,	Day, Year) 200 6
3H8+1		80. Name and address of person who comp	leted cause of de	ath (Item 2	(3a) (Type,	Print)	CT	11	aga	nate	wn.	MD	21740
Stat Registra		31. Date filed (Month, Day, Year)	32. Registra	r's Signatur	re A	whi		,	0				

Charles 06 <b>-</b> 1733	R. A	Pl	ease Type or Pr # 23a.27.28a-f	rint in Black perME.G853_	Indelible 3/27/06	e Ink.	Ensure	All Copie	s Are	Legible.	
AKG		1 - State Registrar	23a,27,28a-f State of N		epārtmer Certificat			Mental H	ygiene Reg. No		07504
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d	xamine	800 Millwood	Drive		Fall	stor				. County of Deat Harfo	ord
	neral ector	5. Social Security Number 216-90-4818	1 🖾 M 2 🗆 F	Age (In yrs. last birth	'rs. If Under		If Under 24 Hr. Hours Mir	8. Date of E (Month, I Aug.	Day, Year)	9. Birtl Co	nplace (State or Foreign untry) MD
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th with	ust be	800 Millwood	Drive			2104	<b>.</b> 7			USA	,
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036 urs af		3 □ Widowed 4 □ Divor	Married 1 X Yes 2[	□No			Specify:	, 0,0.,		Specify:	White
15-00:	it. Ibe Medical	15. Dece (Specify only hi	dent's Education ahest grade completed)	16a. I	Decedent's Usu (Give kind of wo	al Occup	ation during most of we d)	orking	16b. K	ind of Business/	Industry
1215- within 72	W S	Elementary/Secondary (0-1	2) College (1-4d	or 5+)	Financ				A111	to Show	Case
Hygin Hygin	vent.	17. Father's Name (First, Midd	ile, Last)		_ r Illalic	e Ma		ıme (First, Midd			- Cabe
rlan	atic ev		rose				Doro	thy L. (	Green		
ore, Maryland 21215-0 s 1 end 2 should be filed within 72 ho if Health and Merital Hygiene	e m	19a. Informant's Name/Relati	onship (Type, Print)	19b.	Mailing Address	(Street	and Number or F				Zip Code)
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Baltimore,	eny injury or o	· ·	on 3 Removal from Sta	ite cemetery	r, crematory or c	other plac	matory 3			,	
Baltir Permit. P	i i	21. Signature of Funeral Segu		) Journ			ss of Facility			nfield, stersto	
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		23a. Part1. Enter the disease shock, or heart failure.	, or complications that call List only one cause on each	sed the death. Do no							Approximate Interval Between
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68760	the b		d								
Box 6	for use est	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcor	me of pregnancy						23d. Date of del	ivery
O. Bc	letached for use es the bu	in the past 12 months?		2 ☐ Fetal death t at time of death	3 ☐ Ectopic p 5 ☐ Other (sp		<u>'</u>		-	Month	Day Year
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<b>v</b> 8		artii. Other significant com	unions contributing to death		the underlying o	ause giv	90 in Part I.		Yes 2		the cause of death? obably 4 Unknown
ecc law re	2 N							24a. Wa	as an topsy	prior to o	topsy findings available completion of cause of
E The	page .				_			1 Yes	formed?	death?	
of Vital F	rector,	examiner?	Hospital:			Oth		eath (Check on)			
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or Atte	led in by the funera	3 Suicide 6 MCo 4 Homicide det	ermined 28e. Place of building,	Injury - At home, fare etc. (Specify)	m, street, factor	y, office		28f Location City or T	(Street ar	nd Number or Ru e) 800 Mill	ural Route Number,
Ospital o	led i		Home					Fallsto	on, MD		
I 4 n	completely filled in by the	29a. Certifier 1 ☐ Certi (Check only ※X Medi one)	fying Physician: To the be cal Examiner: On the basis and manner	s of examination and	death occurred Vor investigation	at the tin	ne, date and place pinion, death occ	e, and due to the curred at the time	ne cause(s e, date an	) and manner as d place, and due	stated. to the cause(s)
To the within 2	compl	29b. Signature and title of cer			29	c. Licens	e number		29d. Da	ite signed (Monti	h, Day, Year)
	,	There.	M. Kina	()		(	O.C.M.E.		1	March 11	, 2006
	1	30. Name and address of per	son who completed calls	of death (Item 23a) (	Type, Print)	o C+-	root D-	1+ima	7.4-		21 201
		31. Date filed (Month, Day, Y	le King	iştrar's Signature	rii keu	.ı bt.	reet, Ba	ттппоте	, ran	yrand	21201
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ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 07505 Certificate of Death Reg. No. 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** BARKER RICHARD 8,\_ MARCH 2006 0941 /Medical 4b. City. Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner APT. 904 BALTIMORE 500 VIRGINIA AVENUE TOWSON 7. Age (In yrs. last birthday) If Under 1 Year II Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** 1**X** M 2□ F Months Days Hours Min Yrs. 217-42-5782 61 2/4/1945 MARYLAND Director Usual Residence of Decedent 10c, City, Town or Location 10d. Inside City Limits 10a State 10b. County r then "naturel", or Items 23a or 28a-f ehow the Medical Examinar must be notified at 1 ☐ Yes 2 No BALTIMORE TOWSON MD Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 500 VIRGINIA AVENUE APT. 904 21286 USA death Funeral 12. Was Decedent Ever in U.S. Armed Forces? ※☐ Yes 2 ☐ No If Yes, Give Year or DatesVietnam 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 Specify: WHITE 1 ☐ Yes 2 ☐ No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) GRAPHIC ARTISIT SELF EMPLOYED 12TH GRADE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be fill ment of Health and Mental H lant: If Item 27 Is marked ot RITA MULLANEY CARL BARKER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1303 SANDWORT COURT UNIT 204 BELCAMP, MD 21017 JEFF CLARK/COUSIN 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State permit. Page Depertment of Important: If eny injury or once. 3/10/2006 CATONSVILLE, MD METRO CREMATORY, INC. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, P.A. 21. Signature of Fungral Service Licensee 8521 LOCH RAVEN BLVD., TOWSON, MD 21286 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final SUDDEN CAUDIAL DEMTH SYNDROME **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner MES AND I UM YORMMIT Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury 25 Yrs The law requires that the death certificate be executed burial-transit Arron Exami DRUNNM that initiated events attending physicien end resulting in death) Last Due to (or as a consequence of) Box 68760, Physician/Medical as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) Ö 9☐ Unknown 9 Unknown ۵ ete has been signed I page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Records. 1 Ves 2 No 3 Probably 4 Unknown ATRIM FIBRILLATION Completed BACCO ADDICTION 24a. Was an autopsy performed?
1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2☐ No HYPERCIPIDENA this certificete Division of Vital or Attending Physician: After this certific funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one) Hospital: 1 | Inpatient | 2 | ER/Outpatient | 3 | DOA Other: 4 Nursing Home 5 Hesidence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manger of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. 2 Accident investigation the Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, larm, street, lactory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 | Homicide 24 hours e 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medicai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 29b. Signature and title of certified 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MID CAST 32. Registrar's Signature 31. Date filed (Month, Day, Year) Registrar 3 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend items 10b ce f per fit 854 4 4 16 and Mental Hygiene 1 6 Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month Year **Physician** 6500 AM Doris Ann Baker March 06 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner AGNES BALTIMORE If Under 1 Year | If Under 24 Hrs. SAINT HOSPITAL N/A 8. Date of Birth (Month, Day, Year) May 20, 1 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days Months Hours 1 ☐ M 2 💢 F 77 Yrs 1928 215-22-3445 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Baltimore Catonsville MD - Anne Arundel Pasadena 1 Yes 2 No **Funeral Director** 10e, Street and Number 912 South Rolling Road 21228 10g. Citizen of What Country? 10f. Zip Code 1496 Ascot Drive 21122 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 ☐XNo If Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yes 2 No Specify: White Specify: Be Completed by 3 XWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 10 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Frederick Straughn Dorothy Chaplain 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Debra Holub Daughter 1496 Ascot Drive, Pasadena, MD 21122 20b. Place of Disposition (Name of cemetery, crematory or other place)
MeadOWTIdge 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State Donation 5 □ Other (Specify) 3-10-2006 Elkridge, MD Memorial Park Signature of Funding 22. Name and Address of Facility Ambrose Funeral Home, Inc. 1328 Sulphur Spring Rd., Arbutus, MD 21227 Part1. Enter the disease, or complications shock, or heart failure. List only one cause Approximate Interval Between Onset and Death ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, each line. atheroscleratio cordiovoscular desi mediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Physician/Medical Examiner Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 22 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1☑ Yes 2☐ No 24a. Was an 2 No 25. Was case referred to medical examiner? Be 26. Place of Death Check only one Hospital: 1 / Inpatient Medical Certification: To 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Naturat 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

The law requires that the death certificate be executed Physician: or Attending To the Hospital within 24 hours of To the Funeral Completely filled

**Funeral** 

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Physician

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Maryland 21215-0036

Baltimore,

State Registrar

31. Date filed (Month, Day, Year) MAR 1.3 2006

29b. Signature and title of certifier



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

29d. Date signed (Month, Day, Year)

march 7, 2006

		-	For State Registrar	State of M	larylan		artmen rtificat			Mental Hy	Reg. No.	16	0750	)7
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Division To the Hospital or Attention Within 24 hours after death	To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medical (	29a. Certifier 1 Certifying P (Check only one) 1 Medical Exa	hysician: To the bes miner: On the basis and manner:	of examina	wledge, deat tion and/or in	h occurred ivestigation	at the tin	ne, date and pla pinion, death oc	ce, and due to the curred at the time	e cause(s) and m , date and place,	anner as	stated. to the cause(s)	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] [] Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 11:22 AM March atherine 2006 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** Shady Grove Adventist Hospital Rockville Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. July 29, 1925 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex 9. Birthplace (State or Foreign **Funeral** Months 1 □ M 2 🖾 F 032-14-3886 80 Massachusetts Yrs Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ir than "natural", or itams 23s or 28e-f ahow the Medical Exporter rount be notified at 1 ☐ Yes 2 X No Funeral Director Potomac Maryland Montgomery 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 20854 United States 1515 Dunster Road deeth 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after a Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural," or Item any injury or other traumatic avent, the Middle Exempted 1988. Black, White, etc. 1 ☐ Yes 2 ⊠ No ff Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2☑ No Specify. Specify: White Be Completed by 3 Nidowed 4 Divorced 16a. Decedent's Usuaf Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Colfege (1-4or 5+) Own Home Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Anna Schiappa Giovanni Nania 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1061 Grand Oak Way, Rockville, Maryland 20852 Caroline M. Raistrick/Daughter Baltimore, 20b. Place of Disposition (Name of cometery, crematory or other place)
Montgomery Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State March 9, 4 ☐ Donation 5 ☐ Other (Specify) Bethesda, Maryland 2006 Crematorium, Inc. 21. Signature of Funeral Servin Licenses Robert A. Pumphrey Funeral Home/Rockville, Ir 300 West Montgomery Ave., Rockville, MD 20850-2805 M00198 6 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Finaf Sepsis Pnysician 7 days disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Meya coion JOKIC Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of). Physician/Medical Examiner The law requires that the death certificete be executed the attending physicien and hed for use es the buriel-transit Clostrictium resulting in death) Last Due to (or as a consequence of Box 68760. IF FEMALE: 23c. If yes, outcome of pregnancy 1☐Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. I 1 ☐ Yes 2 ☑ No 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by of Vital Records. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy 2/2 No 1 Yes or Attending Physician: After this certification, it To Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospitaf: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Division 1 Matural 5 Pendina s efter death.
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id in by the fun investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Ptace of fnitury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours er To the Funeral C completely filled pelli Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) THY STLIAM 00063088 30. Name and address of person who completed cause of death (ftem 23a) (Type, Print) Kus togi 9901 Medical Center Drive, Rockville, Maryland 20850 MO 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

Patrick J. 1 06-01673	Brı	ino, Sr. Pleas	e Type or Prin	nt in Black	( <u>Indelib</u>	<u>l</u> e Ink.	. Ensure A	II Copie	s Are l	Legible.	
crn		Please Unpen ditem#23  1 - For State Registrar	a,27,28a-t, per State of Ma		/18/06 T epartme <i>Certifica</i>			Mental H	ygiene Rog. No.	006	07509
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and and m 27		Lacey L. Bruno /	Wife				nt Place,	-			D.C. 20015
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Depertment of Health and Mental Hygiene. Important: if item 27 is marked other then "natural", or iteme 23a or 28a-1 ehov eny injury or other treumatic event, the Medical Examinal must be notified at once.		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3	☐Removal from State	cemeter	Disposition (N y, crematory or	r other plac		ch 13,		cation - City or	
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Balti permit. Depertri importe eny inju		21. Signature of Funeral Service Lice	ensee		Robert	A. Po	ess of Facility umphrey Fu	neral Hon	ne / Rocl	kville, I	nc.
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		23a. Part1. Enter the disease, or co shock, or heart failure. List on	mplications that caused by one cause on each lin	ne.	ot enter the m	ode of dyln	ng, such as cardiad	or respiratory	arrest,		Approximate Interval Between Onset and Death
Pnysician	1	Immediate Cause (Final disease or condition resulting in death)	_a. Cocaine in	ntoxicatio	n						
/Medical Examiner		1	Due to (or as	a consequence o	of):						
	-	Sequentially list conditions, if any, leading to immediate	b. Due to for as	a consequence o	effe.						<u> </u>
bet nsit	xamine	Cause (Disease or injury									
sxecuted n and al-transit	Exai	that initiated events resulting in death) Last	c Due to (or as	a consequence of	of):						
68760, tificate be ext g physician as the burial-			4								
687 tifficate ng phy as the	edic										
. Box 68760, death certificate be executed e attending physician and of for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	of pregnancy	- Or				1	23d. Date of del	livery
. B. death death death	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant at	2 Fetal death time of death	3 □Ectopic 5 □ Other (		y 			Month	Day Year
P.O. hat the de deby the defeached	hys	9 Unknown	9□ Unknown								
<u> </u>	by P	Part II. Other significant conditions	s contributing to death be	ut not resulting in	the underlying	g cause giv	ven in Part I.	23e. Did	i tobacco u	ise contribute to	the cause of death?
ord by								1	Yes 2	□No 3□Pr	obably 4XUnknown
aw requ	piet							24a. Wt		24b. Were au	utopsy findings available completion of cause of
II Re(	Completed							pei	opsy formed? 2 \( \subseteq \text{No}	death?	
	0	25. Was case referred to medical					26. Place of Dea				
of Vita Physicien: This certifica	ToB	exeminer? 1 ☐ Yes 2 ☐ No	Hospital: 1 Inpatie	ent 2 ER/Ou	patient 3 🗆 [	DOA Oth	her: 4 🗌 Nursing H	lome 5 Re	sidence (	6 □Other (Spe	city)
On Of ding Ph After th tuneral		27. Manner of Death 1 □Natural 5 □ Pending	28a. Date of Inju (Month, Day	ry 28b. T y Year) Ir	ime of	28c. Injur Wor	ry at rk?	28d. Describ	e how injur	y occurred	
Vision Attending or death. ector: After by the fune	atic	2 Accident investigat	from Find $3/7/200$		1:45 PM		Yes 2 XNo	unk			
Divisic lor Attenc after death Director:	Certification:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine		ury - At home, far c. (Specify)	rm, street, facto	ory, office		28f. Location City or 7	(Street an	d Number or Rule   8701 S14	ural Route Number, epy Hollow Ln.
DIVISION PRIMED OUTS After COURS After COURT After COURT (Filled in by the	Se			at home				Potomac	e, MD	0,01 01	sepy norrow in.
Hospital 24 hours a Funeral I	edicai	(Check only 21\) Medical Ex	Pnysician: To the best caminer: On the basis of	f examination and	, death occurre	ed at the tir	me, date and place opinion, death occu	, and due to th	e cause(s) e, date and	and manner as place, and due	s stated. to the cause(s)
To the Hose within 24 h	Med	one)	and manner sta	ated.							
S T With	-	29b. Signature and title of certifier	$\sim$ $\Omega$	00.	2		se number			te signed (Mont	
V all		7 ot we	mica-10	thil.	9	0.0	C.M.E.		Marc	h 09, 2	006
301 2		30 Name and address of person wh	DIL	eath (Item 23a) (	• •	nn C	treet, Ba	1timor	o Mo	rarl and	21 201
Sta	ite	31. Date filed (Month, Day, Year)	32. Registra	ar's Signature			LICEL, D	T CTIIOU	e, rid	тутани	<b>∠1</b> ∠∪1
Registi		MAR 1	3 2006	was the	Spark						

		Registrar			Cert	ificate of	Dealli		Reg. f	No. U U U	OIOI
Physician /Medical	1	1. Decedent's Name (First, Middle, La Jeannette	st)	Br	uns			Mon	of Death th (	Day Year	3. Time of Dea
Examiner uneral	4	Howard Country Number 6. Social Security Number 6. S	ty Gener	)	st birthday)	4b. City, Town, o  Coli  If Under 1 Year  Months Days	If Under 24	Hrs. 8. Date	of Birth th, Day, Yes	4c. County of De	ath
> 2.	1	Usual Residence of Decedent 10a. State 10b. County MD Howa:	rd	10c. City,	Town or Loca		1		14/13	30	10d. Inside City Li
to or 28a-f show the nutified at Director	-	10e. Street and Number 3420 Shady Lane				lenwood.  10f. Zip Code	1738		10g. (	Citizen of What C	1 Yes 2 Country?
al, or items 23a or 28a-f si xar-inerroust be notified by Funeral Director	y - discipa	11. Marital Status 1 □ Never Married 2 🔀 Married	12. Was Decedent Armed Forces' 1  Yes 2 1	?	lf `	as Decedent of H Yes, specify Cuba	lispanic Origin	? (Specify Yes uerto Rican, et	or No-	14. Race - Am Black, Wh	
"natura adical E		3 Widowed 4 Divorced  15. Decedent's E (Specify onfy highest gra Elementary/Secondary (0-12) 12		5+)	(Give ki	int's Usual Occup ind of work done O NOT use retired	during most of d)	working		Kind of Busines	s/Industry
is marked other than sumatic avant, I's M.	1	17. Father's Name (First, Middle, Last, Bernard Bihn	)					Name (First, A Cella W		len Sumame)	
am 27 is ma		19a. Informant's Name/Relationship ( Edward Bruns / Hu				Address (Street Shady La				y or Town, State, 738	Zip Code)
int: If itam		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3√5 1 ☐ Donation 5 ☐ Other (Specif	(y)	Lake	e Towns	tion (Name of atory or other place Ship Cem		Date /4/2006	M	Location - City of 111bury,	OH
Important: I any injury o once.		21. Signature of Funeral Service Licer	Victor	P. Doo	da, Jrº?	Name and Addre Charles	ss of Facility L. Ste	evens F	uneral	L Home,	Inc. MD 21230
sician edical iminer		Immediate Cause (Final disease or condition resulting in death)	a. Cov Due to (or as	Mac a conseque	7 .	rrest					1 da
sician and burial-transit		Sequentially list conditions, and the sequentially list conditions, and cause (Disease or injury that initiated events resulting in death) Last	b. Coro	a conseque	Artery ance of	Disease	2				
by the attending physicial ached for use as the but ached for use as the but ached for use as the but ached for all any Medical		Cause (Disease or injury that initiated events	Due to for as	a conseque a conseque of pregnan 2   Fetal c	Artery ance of:  ance of):  cy death 3   E	Disease				23d. Date of d Month	
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	State of Maryland / De	epartment of Health and Mental Hygien  Certificate of Death  Reg. N	°nns n7511
Physician /Medical	1. Decedent's Name (First, Middle, Last)  Milford Wavery Case	2. Date of Death Month Di	ay Year 3. Time of Death 9:20 6 9:27 AM
Examiner	4a. Facility Name (If not institution, give street and number)  Sina; (+05 Piter) Of Baltimon	4b. City, Town, or Location of Death  3 (14 NOVE	c. County of Death
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. last birth 1.2 1.2 1.2 1.2 1.2 1.2 1.2 1.2 1.2 1.2	rs. If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year 09/05/1926	
Maryland febow	Usual Residence of Decedent  10a. State  10b. County  10c. City, Town		10d. Inside City Limits 1 ⊠Yes 2 □ No
death with the Maryland rms 23e or 28e-1 ehow rmunt be re-tiffed at neral Director	Maryland Bal:  10e. Street and Number  4114 Fordleigh Road		Citizen of What Country?
ē 2 5 5	11. Marital Status  1 Never Married 2 Married  1 Never Married 2 Married  3 New Midowed 4 Divorced  12. Was Decedent Ever in U.S. Amed Forces?  1 Never Married 2 Married 11. Was Decedent Ever in U.S. Amed Forces?  1 Never Married 2 Married 12. Was Decedent Ever in U.S. Amed Forces?  1 Never Married 2 Married 12. Was Decedent Ever in U.S. Amed Forces?  1 Never Married 2 Married Page 1 Never Married 2 Married Forces?  1 Never Married 2 Married 2 Married 1 Never Married 2 Married 2 Married 1 Never Married 2 Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 2 Married 1 Never Married 2 Married 2 Married 1 Never Married 2 Married 2 Married 1 Never Married 2 Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 2 Married 1 Never Married 2 Married	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  1 ☐ Yes 2 🏋 No Specify:	14. Race - American Indian, Black, White, etc.  Specify: Black
1215-0 within 72 hc ans. than "nature in Mudical completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  9  16a. I	Give kind of work done during most of working life. DO NOT use retired)	Kind of Business/Industry  S. Post Office
aryland 2 should be filed and Mental Hygie smarked other umatic event. To Be CC	Mathias Case	18. Mother's Name (First, Middle, Maide Lady Bird Midgett	
re, Maryla s 1 and 2 should t Health and Mer Item 27 is marke other treumatic	Margo Anderson / Daughter 411	Mailing Address (Street and Number or Rural Route Number, City 4 Fordleigh Road, Baltimore, N	Maryland 21215
Itimo ii. Page artment o ortent: if injury or	1 Manual 2 Cremation 3 Hemovalitom State 1	Disposition (Name of committee) Date 200.1  On Forest Ceme 03/14/2006 Owing 22. Name and Address of Facility The Derrick (	
Ba pern limpo any any	23a. Part1. Enter the disease, or complications that caused the death. Do no	+4611 Park Hgts. Ave., Balting of enter the mode of dying, such as cardiac or respiratory arrest,	Approximate Interval Between
Physician /Medical	shock, or heart failure. List only one cause in each line.  Immediate Cause (Final disease or condition resulting in death)  a. Qurd Q Due to (or as a consequence of	rest	Onset and Death
7760, Ite be executed when yield and burial-transit and cal Examiner	s and the state of		
O. Box 687 ne death certificate the attending phy- hed for use as the ysician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown  23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown	3□Ectopic pregnancy 5 □ Other (specify)	23d. Date of delivery Month Day Year
Cords, P.( w requires that the been signed by should be detacted by Physical Cords of the cords	Part fl. Other significant conditions contributing to death but not resulting in	the underlying cause given in Part I. 23e. Did tobacco	o use contribute to the cause of death?
If Records, The law requires the page 2 should be completed by		24a Wasan autopsy pentormed? 1 ☐ Yes 2 AN	
Division of Vital Rallor or Attending Physicien: The after death.  Director: After this certificate he in by the funeral director, page ertification; To Be Com	25. Was case referred to medical examiner?  1   Sylves   2   No		
Division c tel or Attending P is after death. el birector: Atter I ed in by the funera Certification;	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm building, etc. (Specify)	m, street, factory, office  28f. Location (Street & City or Town, Sta	and Number or Rural Route Number, ite)
Division of To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral Medical Certification:	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, 2 Medical Examiner: On the basis of examination and and manner stated.	death occurred at the time, date and place, and due to the cause for investigation, in my opinion, death occurred at the time, date a	(s) and manner as stated. Indiplace, and due to the cause(s)
To the Common	29b. Signature and title of certifier	29d. E	Date signed (Month, Day, Year)
712	30. Name and address of person who completed cause of death (ftem 23a) (1	ype, Print Bottera	Jana- 21215
State Registrar	31. Date filed (MCath Ray 1703) 2006 Registrar's Signifure	godi)	

pt. Known as Milford Case

CHRISMOND

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ies	st Carte	er	For State Registrar	State of Marylar		artment of F <i>rtificate of</i>			7 1111	6 07513
			Registrar  1. Decedent's Name (First, Middle, Las	st)		Tillicate Of	Dealit	2. Date of Dea	th	3. Time of Death
	Physicia		Ernest McCoy					Month March	Day Y	006 9:00A M
П	/Medio Examin		4a. Facility Name (If not institution, give	e street and number)		4b. City, Town, o	r Location of Death		4c. County of	Death
4	Lamin	CI	John Hopkins Ho	snital		Balı	timore			N/A
	Funeral		5. Social Security Number 6. S	ex 7. Age (In yrs.		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day	8 1942	9. Birthplace (State or Foreign Country)
	Director		215-47-5543 1 Usual Residence of Decedent	ØM 2□F 64	Yrs.			Jan 1	8,1942	VA
	land		10a. State 10b. County	10c. Ci	ty, Town or Lo	ocation				10d. Inside City Limits
	Mary Ff sh	ğ	WD	/A Ba	altimo	ore				1 🛣 Yes 2 🗆 No
	iges 1 end 2 should be filed within 72 hours after deeth with the Maryland nt of Health and Mental Hygiene. If item 27 is marked other then "natural", or items 23s or 28s-f show or other traumatic event, the Madical Examinar must be notified at	Director	10e. Street and Number 2419 Guilford	Ave 1st Flo	oor	10f. Zip Code	21218		10g. Citizen of Wr	nat Country? USA
	leeth ns 23	by Funeral	11. Marital Status	12. Was Decedent Ever in U		Was Decedent of H	Hispanic Origin? (S	pecify Yes or No-	14. Race	- American Indian,
9	or iter	골	1 ☐ Never Married 2 ☐ Married	Armed Forces?	1	1 ☐ Yes 2 ☑ No		o Hican, etc.)		White, etc.
ğ	ral', c		3 Widowed 4 Divorced	If Yes, Give Year or Dates:		ILITUS ZAJINO	Зреспу.			Black
2	natu dical	etec	15. Decedent's Ed (Specify only highest gra	ducation ade completed)	(Give	dent's Usual Occup kind of work done DO NOT use retire	during most of wor		16b. Kind of Bus	
12	within ene. then	Completed	Elementary/Secondary (0-12) 12th	College (1-4or 5+)	1116.	Labore	•		Private	Industries
р 5	filed Hygin		17. Father's Name (First, Middle, Last,	)			18. Mother's Nar	ne (First, Middle,	Maiden Surname,	)
lan	id be lental ked c	To Be	Ernest Jones				Clemer	ntine C	arter	
Maryland 21215-0036	12 shouh and N		19a. Informant's Name/Relationship ( Shirley Carte		19b. Maili 241	ng Address (Street	and Number or Ru	ıra <i>l Rout</i> e Numbe 1st Fl	r, City or Town, s r Balti	tate, Zip Code) 21218 More MD
	Healt Healt tem 2	1	20a. Method of Disposition	20b.	Place of Dispo	osition (Name of		Date	20c. Location - C	City or Town, State
Baltimore,	permit. Pages Department of i Important: If it any injury or o	1 8	1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif	Removal from State T:	rinity, cre.	matory or other pla Y Cemete	ery 3/16	5/2006	Dundal	k MD
Ħ	nit. F vartme ortan injur	li	21. Signature of Funeral Service Licer		2	2. Name and Addre	ess of Facility Ch	natman-	Harris	Funeral Home
ä	Per	5	Versy Ho	ins	52	240 Reis	sterstov	vn Rd B	altimor	re MD 21215
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the dea	th. Do not en	ter the mode of dyi	ng, such as cardia	or respiratory ar	rest,	Approximate Interval Between
1	Physician		Immediate Cause (Final disease or condition	Atherosclero	fic c	ardiovasc	iular d	isease		Onset and Death
A.	/Medical Examiner		resulting in death)	Due to (or as a conse	quence of):					
	LAdinate	_	Sequentially list conditions,	b. Due to (or as a conse	quence of):					
	ted nsit	n P	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	555 15 (5. 25 2 50.155	420.000 0.7.					
Ć,	be executed icien and burial-transit	Examiner	that initiated events resulting in death) Last	C. Due to (or as a conse	quence of):					
760,	0 % 0	cai	(	d						
89	death certificate to a stending physical of for use as the to	Physician/Medl	IF FEMALE:					-		
Вох	ath ce ttendi	lan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregr 1 ☐ Live birth 2 ☐ Fet	al death 3	Ectopic pregnanc	Ey .		23d. Date Mont	of delivery th Day Year
	0 0 0	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at time of 9☐ Unknown	death 51	Other (specify)				
P.O.	that the de ed by the detached	H.	Part II. Other significant conditions	contributing to death but not re	sulting in the u	underlying cause gr	ven in Part I.	23e. Did to	obacco use contrib	oute to the cause of death?
ds	sign d be	d by						101	res 2□No 3	3 ☐ Probably 4 Munknown
00	s been should	Completed						24a. Was	an 24b. W	ere autopsy findings available
R	The lav	E						autor perfo	med? de	ior to completion of cause of eath? □ Yes 2 □ No
ital		Be C	25. Was case referred to medical examiner?				26. Place of De	ath (Check only o		
Ž	G is %	10	1 XYes 2 No	I	ER/Outpatie	INT SELL DOM	<u>-</u>		dence 6 Other	
n C	ing Ph After th uneral		27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o	Wo	ork?	28d. Describe	now injury occurre	d
isic	Attending ir death. ector: After by the fune	Icat	2 Accident investigation 3 Suicide 6 Could not be	08 Otago of Injury At	home farm st		]Yes 2 □No	28f. Location (5	Street and Numbe	r or Rural Route Number,
Division of Vital Records,	after Direction by	Certification:	4 ☐ Homicide determined	building, etc. (Spec		troot, ractory, critical	·	City or To		
	To the Hospital or Attending F within 24 hours after death. To the Funerel Director: After completely filled in by the funer		29a. Certifier 1 ☐ Certifying P	hysicien: To the best of my kr	nowledge, dea	th occurred at the t	ime, date and place	e, and due to the	cause(s) and man	nner as stated.
	he Ho in 24 he Fu	Medical	(Check only 2 Medical Exa	miner: On the basis of examinand manner stated.	nation and/or ii					
	To the Vithin 2 To the complet	Σ	29b. Signature and title of certifier	6			ise number			(Month, Day, Year)
	ñ			mis			O.C.M.E.		March	8, 2006
,	2		30. Name and address of person who	completed cause of death (Ite	em 23a) (Type		enn Stree	t Balti	jore, Ma	aryland 21201
	Sta Regist	ate	31. Date filed (Month, Day, Year)	32. Begistrar's Sign	nature					
	negist	rai	MAR 1 3 2	006 Been	Ar My					

			State of Maryland / Department of Health and  1- State Registrar  Certificate of Death	Mental Hyg	_	5 07514
	Physici	ian	1. Decedent's Name (First, Middle, Last)	2. Date of Dea Month	th Day Yea	3. Time of Death
	/Medi	cal	Anthony Hynson Comegys  4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Dea	March	9 20	
	Examir	ner	Union Memorial Hospital  Baltimore	цп	4c. County of D	N/A
	Funeral Director		5. Social Security Number 216-10-1122 6. Sex 94 7rs.   The security Number 216-10-1122 1 Representation of the security Number 216-20-20-20-20-20-20-20-20-20-20-20-20-20-		,1911 9.	Birthptace (State or Foreign Country)
	land		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
	Mary n-f ah	tor	MD N/A Baltimore			Y⊡Yes 2 □ No
	ith th	Dire	10e. Street and Number 10f. Zip Code		0g. Citizen ol What	
	a 23a	eral	3530 Greenmount Ave 21218  11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (9)	S	US	
<b>'</b> O	r item	Funeral Director	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 Never Married 2 Married  1 Yes, specify Cuban, Mexican, Puel	rto Rican, etc.)	Black, W	merican Indian, /hite, etc.
9	ours a	þ	If Yes, Give 1 ☐ Yes 2 ▼ No Specify: Year or Dates:		Specify: I	Black
5	natu natu	etec	15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of work life. DO NOT use retired)	orking	16b. Kind of Busine	ss/Industry
12	filed within 72 hours after death with the Maryland Hygiana. ther than "natural", or floma 23a or 28a-f ahow int, the Medical Examiner must be notified at	Completed	Elementary/Secondary (0-12) 12th  College (1-4or 5+) Supervisor		Cat Paw	Rubber
ğ	e filed al Hyg other	BeC	17. Father's Name (First, Middle, Last) 18. Mother's Na	ame (First, Middle,	Maiden Sumame)	
<u>yla</u>	should be filed within 72 hours after death with tha Marylan and Mantal Hygiana. s marked other than "natural", or itema 23a or 28a-f ahow umatic avant, the Medical Examiner must be notified at	10	Ellilla H			
e, Maryland 21215-0036	as 1 and 2 should b of Haalth and Mant itam 27 is markac r other traumatic a		19a. Informant's Name/Relationship (Type, Print) Daughter 19b. Mailing Address (Street and Number of R Beverly Anthonette Comegys 3530 Greenmount Av	and the second second		
altimore,	permit. Pages 1 Dapartment of H important: If ita any injury or ott		4 Donation 5 Other (Specify)		20c. Location - City Lansdowr	ne MD
Ball	permit. Page Dapartment Important: If any injury or		21. Signature of Funeyal Service Licensee  22. Name and Address of Facility Ch  5240 Reistersto	atman-H wn Rd B	arris Fu altimore	neral Home MD 21215
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardia shock, or heart failure. List only one cause on each line.	ac or respiratory arr	est,	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)  a. Acute on Chronic Renol Failure			3 days
	Examiner		Due to (or as a consequence of):  b. Hypertens con			44 7
	ם פ	ner	Sequentially list conditions b. Due or as a consequence of): cause. Enter Underlying Cause (Disease or injury			Many Years
	and and I-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a cos equence of):			Many Lears.
8760	certificata ba axacuted inding physician and ise as the burial-transit	ical E	4			
Ö	tificat ng phy as the			-		
.O. Box	ath itter	Physician/Med	IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1 □ Yes 2 □ No 9 □ Unknown  23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify) □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □		23d. Date of Month	delivery Day Year
ر. ح	res that the da signed by tha a be detached f	by Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did to	bacco use contribute	e to the cause of death?
ecords,	w require been sig should b			1 🗆 Y	es 2 □ No 3 □	Probably 4 Unknown
Ť	The law re the has be bage 2 sho	Completed		24a. Was a autops perform	ry prior death	autopsy findings available to completion of cause of ?
Vital	Physician: The la r this certificate have aral director, page 2	Bec	examiner?	eath Check only on		55 2 110
6	Physi this c	٦.			ence 6 Other (S	pecify)
5	ding th. : After funer	Certification:	27. Manner of Death  1 Snatural 5 Pending (Month, Day Year)  2 Accident investigation  28a. Date of Injury 28b. Time of Injury 32b. Time of Injury 4 Work?  1 Yes 2 No	28d. Describe ho	ow injury occurred	
DIVISION	Attar actor by the	Iffica	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, larm, street, lactory, office building, etc. (Specify)	28I. Location (Si	reet and Number or	Rural Route Number,
5	ital or ars afte ral Dir llad in			City or Town		
	To the Hospital or Attanding Physicien: within 24 hours after death. To the Funeral Director: After this certifical complataly filled in by the funeral director,	Medical	29a. Certifier  (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place (Check only one)  Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place (Check only one)	e, and due to the courred at the time, d	ause(s) and manner ate and place, and o	as stated. due to the cause(s)
1	or Marie A	2	29a. Certifier (Check only one)  1  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place (Check only one)  2  Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place and manner stated.  29b. Signature and title of certifier  29c. License number  A T 24 38 9 4  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  SHAD™ BARAKAT, MD Union Memorial Hospital  31. Date filed (Month, Day, Year)  MAR 1 3 2006  MAR 1 3 2006	46-4	9d. Date signed (Me March 9	, 2006
-	) `		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  SHADS BARAKAT, MD Union Memorial Hospital	, MD		
	Sta Registra		31. Date filed (Month, Day, Year)  MAR 1 3 2006  32 Pegistrar's Signature			
DLIF	H 17 Bay 1/20	204				

			- For Amend Item	State of Ma 2 per D	aryland r.,G8	1 / Depa 56 ,ළදු	artment o	of He	ealth a Death	ind Me	ntal Hyg	iene	006	)	07515
	Physici		1. Decedent's Name (First, Middle, Last)	CALI	'CA	-					Date of Deat Month		01/20	)06 ar	3. Time of Death
	/Medic Examir		4a. Facility Name (If not institution, give st	reet and number)			4b. City, Tow	DA	7-65	TOU	MARCH N	130	County of E	SA	we
	Funeral Director		5. Social Security Number 6. Set 113	7. Ag	6 (In yrs. Ia 58	st birthday) Yrs.	Il Under 1 You Months Da	ear ays	If Under 2 Hours	Min.	Date of Birth (Month, Day, Feb. 8,	Year) 194		Coun	lace (State or Foreign try) yland
	show	J.	Usual Residence of Decedent  10a. State 10b. County  Maryland Baltimor	0		Town or Lo								11	0d. Inside City Limits 1 □ Yes 2 ☑ No
	with the N 3a or 28a-f	i Director	10e. Street and Number 1228 Canberwell				10f. Zip Coo	de 212	28		1	-	en of Wha	t Coun	try?
980	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other then "natural", or items 23a or 28a-f show other traumatic avant, if a Madical Examinal must be notified at	by Funeral		2. Was Decedent Armed Forces? 1 Yes 2 1 If Yes, Give Year or Dates:			Was Decedent If Yes, specify (	Cubar	spanic Origin, Mexican Specify:	gin? (Speci , Puerto Ri	ify Yes or No- can, etc.)		4. Race - A Black, V Specify:	Vhite,	etc.
Maryland 21215-0036	within 72 ho lene. then "netur the Medicel	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12) 12th	ation completed) College (1-4or 5	5+)	(Give life.	dent's Usual Or kind of work di DO NOT use re Tender	(one di etired)	uring most	t of working			d of Busin re11		
land 2	should be filed and Mental Hygi a marked other umatic avant, II	To Be C	17. Father's Name (First, Middle, Last) (unkno	wn)	1						First, Middle, I tte Br				
	and 2 should beath and Ment m 27 is marked her traumatics		19a. Inlomant's Name/Relationship ( <i>Typ</i> Nancy Calka / wif		Took Bu	1228	ng Address <i>(St</i>	e1:			Catons	ville	e, Ma	ry1	and 21228
Baltimore,	permit. Pages 1 Department of H Important: if Ite any injury or ott		20a. Method of Disposition  1  Burial 2  Cremation 3  Re 4  Donation 5  Other (Specify)		CB	metery, crei Keview	osition (Name of matory or other of Mem. I	r place Par	k :	3/4/2	006	Syke		1e,	Maryland
Bal	permi Depar Impor any ir		21. Signature of Funeral Service License	nuio	ul	w	4001 Ri	tch	nie H	ighwa	y Balt	imor			land 21225
	Physician /Medical Examiner		23a. Part1. Enter the disease, or complice shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)	Due to (or as	eto	Sto	ter the mode of	f dying	such as Slc	cardiac or	les ()	est,	er		Approximate Interval Between Onset and Death
8760,	ate be executed hysicien and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as	_ t	type	perte	n	tio	0		}			
.O. Box 68	ne death certific the attending p thed for use as:	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	ic. If yes, outcome 1 Live birth 4 Pregnant a 9 Unknown	2 Fetal	death 3	⊒Éclopic pregr ⊒ Other (specif				lat 7	23	3d. Date o Month	f delive	eny Day Year
Δ.	en signed by	þ	Part II. Other significant conditions conf	ributing to death b	out not resu	ılting in the u	inderlying caus	e give	on in Part I		1	baccous es 2□		te to th	ne cause of death?
of Vital Records,		Completed									24a. Was a autopo perfor	sy	prio dea	r to co	psy findings available mpletion of cause of
Vita	sician: certific rector,	Be	25. Was case referred to medical examiner?	ospital: inpati	-0.			Othe	ar.		(Check only of			· · · · · ·	
	g Physical dispersal di	n; To	27. Manner of Seath	28a. Date of Inju	ıry	ER/Outpatie 28b. Time o Injury		Injury	4 🗆 🕠		e 5 Resid			Spacii	y)
Division	Hospital or Attanding is 4 hours after death. Funeral Director: After tely filled in by the funer	Certification;	Naturat 5 Pending investigation 3 Suicide 6 Could not be determined	28e. Ptace of In		me, farm, st	М	1 🗆 ነ	res 2□		BI. Location (S City or Tow	itreet and n, State)	l Number	or Rura	si Route Number,
		Medical Ce	29a. Certifier 17 Certifying Phys (Check only one) 2 Medical Examin		of examinat										
	To the within 2 To the complet	Me	29b. Signature and title of certifier	MD					number	5		29d. Date	signed (I	Month,	Day, Year) 2006
	(5)		30. Name and address of person who co	100			Print) N	EL	Hai	05 10 S1 1304	treet	Su	ute Nº7	-39	1201
	St	ate	31. Date filed (Month, Day, Year) MAR 1 3 2006	32. Regist	rar's Signal	ture	ar s				( , ,	_			

		,	For State Registrar	State of M	1arylan		artmen <i>tificat</i>			and M		jiene Reg. No.	006	07516
	Physici	an	1. Decedent's Name (First, Middle,	Last)							2. Date of Dea	Day	Year	3. Time of Death
	/Medic	al	Fernando M.		-1		4h Cih	Taua	I continu	d Dooth	FEBRUA	1	Ounty of Dea	
	Examin	er	4a. Facility Name (If not institution,	,	SPITA	1/	46. City,	130	Location of	MOLI	or I	40.0	NIA	UT
	Funeral		5. Social Security Number	5. Sex 7. A		ast birthday)	If Under		If Under		8. Date of Birtl	h	9. Bir	thplace (State or Foreign
	Director		164-32-1963	15∏ M 2□ F	73	Yrs.	Months	Days	Hours	Min.	(Month, Da) Aug 19	, Year) , 193	2 Bra	azil
	P .		Usual Residence of Decedent		10- 0'5	, Town or Lo								10d. Inside City Limits
	anylai ehov	-	10a. State 10b. County			altimo								1 √2 Yes 2 □ No
	19 M	Director	MD  10e. Street and Number		E	baltimo	10f. Zip	Codo				10a Citiza	en of What Co	Δ.
	with with	ă					101. 21		212			-		Surity :
	ne 23	Funeral	116 Melrose Av	12. Was Deceder		S. 13. V	Was Dece		212 spanic Ori	gin? (Spe	ecify Yes or No- Rican, etc.)		3razil 4. Race - Ame	
ယ	or Itan	Fun	1 ☐ Never Married 2X Marrie	Armed Forces			_			i, Puerto	Rican, etc.)		Black, Whit	
Ö	filed within 72 hours after death with the Maryland Hygiene Han "natural; or Itama 23a or 28a-f show off, I'ra Medical Exam, ar must be notified at	1 by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give 1 Year or Dates	:		1 □ Yes	2 <b>X</b> 1 N0	Specify:				Specify: whi	Lte
21215-0036	72 h	Completed	15. Decedent's (Specify only highest	Education grade completed)		16a. Deced (Give	kind of wo	rk done a	lurina mos	t of worki	ing	16b. Kin	d of Business	/Industry
121	within ne. han	mpi	Elementary/Secondary (0-12)	College (1-4o	r 5+)		DO NOT u	se retired,	)					_
D D	filed v Hygie ther t		12 17. Father's Name (First, Middle, L	0		chef			18. Mothe	er's Name	(First, Middle,		staraı umame)	int
<u>a</u> n	d be ental kad o	То Ве	Arelino C. Cot						Cat	arin	a Marqu	es		
Maryland	2 should be 1 and Mental I Is markad or raumatic eve	1	19a. Informant's Name/Relationshi			19b. Mailir	ng Address	(Street a			I Route Numbe		Town, State,	Zip Code)
ž	Health a tem 27 le		Margeta Cotta/s	spouse		3838	Rola	and A	venu	e #6	95 Balt:	imore	, MD	21211
ore	of He of He fiter		20a. Method of Disposition  1  Burial 2  Cremation	3 DRamoval from Stat		lace of Dispo emetery, crer	sition (Nai	me of other place	θ)	C	Date	20c. Loc	ation - City or	Town, State
Ĕ	Pages ment of I ant: If Its ury or o		' 4 ☑ Donation 5 ☐ Other (Sp.						į					
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Beginning the Marylan Important: If Item 27 is marked other than "natural", or Itama 23a or 28a-1 show amportant if Item 27 is marked other than "natural", or Itama 23a or 28a-1 show amy injury or other traumatic event. Ita Medical Exatr permits the notified at once.		21. Signature 1 Fun-ral Service L Ronald S	Wades Di	ector		2. Name ar tate altir	Anat		Boar 2120		. Bal	timore	Street
			23a. Part1. Enter the disease, or c shock, owneart failure. List o	emplications that caus nly one cause on each	ed the death line.	n. Do not ent	er the mod	le of dying	g, such as	cardiac o	or respiratory ar	rest,		Approximate Interval Between
N	Pnysician		Immediate Cause (Final disease or condition	PROBAL	BLG 1.	NYOCAL	RDIA	(I	-NFI	9RC	TION			UNKNOUN
	/Medical Examiner		resulting in death)	Due to (or a	as a consequ	uence of):								
		-	Sequentially list conditions, if any, leading to immediate	b. Due to (or a	as a consequ	uence of):								
	rted nsit	nin	Cause (Disease or injury	<b>₹</b>		,-								
Ć,	execu in and ial-tra	Examine	that initiated events resulting in death) Last	Due to (or a	is a consequ	uence of):								
8760,	The law requires that the death certificate be executed sie has been signed by the attending physicien and page 2 should be detached for use as the burial-transit	dicai	,	d	_									
9	rtifica ng ph	Med	IF FEMALE:											
Вох	leath certifica attending ph I for use as t	Physician/Me	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcom 1☐Live birth	2 Fetal	Ideath 3[	Ectopic p					23	Bd. Date of de Month	livery Day Y <i>e</i> ar
<u>.</u>	the a	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant 9□Unk <i>n</i> own		eath 5∟	Other (s	oecify)		-				
P.0	that the de ed by the detached		Part II. Other significant condition	s contributing to death	but not resi	ulting in the u	nderlying o	ause give	en in Part I		23e. Did to	obacco us	e contribute t	o the cause of death?
Vital Records,	w requires that been signed b should be deta	d by									101	′es 2 □	No 3□P	robably 4 Mnknown
CO	s beer	olete									24a. Was		24b. Were a	utopsy findings available
Re	The tay te has	Completed									autop perfo: 1 ☐ Yes		death?	completion of cause of s 2 No
ita	iclan: The lav certificete has rector, page 2	Bec	25. Was case referred to medical						26. Place	of Deatl	n (Check anly a			
	Physiclan: r this certifice ral director.	To	examiner? 1 ☐ Yes 2 🗶 No	Hospital: 1 🗆 Inpa	tient 2	ER/Outpatier			4   140	irsing Ho	me 5□Resid	lence 6	□Other (Spe	ecify)
ם	ding Phys n. After this funeral di	ou:	27. Manner of Death 1 X Natural 5 ☐ Pending		jury Day Year)	28b. Time o Injury		28c. Injury Work			28d. Describe h	now injury	occurred	
Sio	ttendi death ctor: / / the fr	cat	2 Accident investiga 3 Suicide 6 Could n	ot be	nium: At he	ama farm str	M feeter		Yes 2		28f Location /9	Street and	Number or B	Tural Route Number,
Division of	after death Director: I in by the	Certification;	4  Homicide determin	building,	etc. (Specify	y)	eet, lactor	y, onice			City or Tox		77071001 0771	oral riouto rearrisor,
	To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificete his completely filled in by the funeral director, page	edical C		Physicien: To the be xeminer: On the basis and manner	of examina									
	To the within 2. To the complet	Me	29b. Signature and title of certifier					c. Liceose						th, Day, Year)
	> - 0		> Stachen	17 B	4	m.I	2	10	426.	58	/	MARC	112	2006
			30. Name and address of person w	nho completed cause	death (Item	1 23a) (Type,	Print)	601	Loc	HI	RAVEN	Bou	LEVARI	<b>&gt;</b>
			STEPHEN G.	HOLTZCLAD	w, MD	)	B	4/711	MORE	M	0 210	734		
	Sta Registr		30. Name and address of person was STEPHEN G. (Month, Day, Year) MAR 1 3	2006 7. Regi	strar's Signa	ture	de							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
Amend item 5 per inf. 8857 7-14-06 vt.
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 20 **Physician** ebruary 28, 2006 Dorothy M. Carter /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number, 4c. County of Death Examiner General 10/6 If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 6. Sex Birthplace (State or Foreign Country) **Funeral** Months Hours Min 1 ☐ M 210 F 224-18-1 Director 89 1916 Virginia Usual Residence of Decedent 10b. County 10c. City, Town or Location 10a State 10d. Inside City Limits 28a-f show dress must be notified at 1√2 Yes 2 □ No Completed by Funeral Director MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 301 McMechen Street #1126 21217 USA items 23a 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 and 2 should be filed within 72 hours after Health and Mental Hygiene. 1 Never Married 2 Married ō 1 ☐ Yes 2 ☑ No Specify: other traumatic event, the Mudical Exam If Yes, Give Year or Dates: 143-45 Specify: black 3 ☐ Widowed 4 🌠 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry other than Elementary/Secondary (0-12) College (1-4or 5+) 12 teacher education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be George Mayfield 9 Ophelia Everrette 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elizabeth Young/niece if item 27 4022 Bateman Avenue Baltimore, MD 21217 timore. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State ā permit. Page Department of Important: if any injury or once. \* 4 X Donation 5 ☐ Other (Specify) . Wade, Director 21. Signature of Furleral Service Lice Ronald 5 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 unes Part 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a. Part1. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** Ulmonak resulting in death) /Medical Due to (or as a consequence of); Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last (or as a consequence of): Physician/Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed as the burial-transit Due to (or as a consequence of): Box 68760. IF FEMALE: use If yes, outcome of pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 4□Pregnant at time of death 5 Other (specify) P.O. be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. by Division of Vital Records. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Inknown funeral director, page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy 2 PNo 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 10 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No death. 2 Accident after death Director: 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical within 24 ho To the Fun completely t (Check only one) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and wdress of person 40 WARL

Registrar

State

31. Date filed (Month, Day, Year)

MAR 1 3 2006

Aces (

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2006 Year Month **Physician** March 11, John Edgar Davis, Sr. 8:00 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 1927 Old Eastern Avenue Baltimore Essex If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) **Funeral** XXM 2 F 72 238-44-4950 North Carolina 5,1933 Director Usual Residence of Decedent with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits ●how r than "natural", or Iteme 23a or 28a-f ehov the Medical Evantiner must be cutified at 1 ☐ Yes **≱**∑No Directo Maryland Baltimore Essex 10e. Street and Number 10f. Zip Code 10g. Citizen of Whal Country? 1927 Old Eastern Avenue 21221 U.S.A. death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after Copartment of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or item any injury or other treumatic event, the Modical Event and 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Marned Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ to Specify: ģ 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Real Estate Real Estate Broker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Eva Priscilla Hollifield Merida Davis 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2110 Tred Avon Road, Baltimore, Maryland 21221 Cynthia Parsram (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Surial 2 ☐ Cremation 3 ☐ Removal from State Holly Hill Mem. Gard. March 14,2006 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Ski Funeral Home, P.A. 21. Signature of Funeral Service Licenses 1407 Old eastern Avenue, Essex, Maryland 21221 Approximate Interval Between Onset and Death Enforthe disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, of heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** +aus Due to (a as a consequence of): t ca vit /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that iniliated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) signed by the at d be detached to 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Junknown should ? Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? certificate has t irector, page 2 s 2 No 1 Yes 2 No 1 Yes or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: ٩ 1 ☐ Yes 2 X No 1 🗌 Inpatient 2 ER/Outpatient 3 DOA ō After thi 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending 1 Tyes 2 No death. investigation Director: / 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 Homicide within 24 hours of To the Funeral McCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie 29b. Signature and title of certifier W41614 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimur, Mas Ю BUL Caughel Alan Halle 4920 31. Date filed (Month, Day, Year) 32, Registrar's Signature State Registrar MAR 1 3 2305

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SEC.	Director		220-07-4239 Usual Residence of Decedent					000. 1,	2722 11	
	land low		10a. State 10b. County		10c. City, Town or I	ocation				10d. Inside City Limits
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9	4 within 72 hours after death with the Maryland Jiene. r than "natural", or Items 23a or 28a-f show the Medical Eventraer must be codified at	Funeral	1 Never Married 2 Married	2. Was Deceden Armed Forces 1 ☐ Yes 2X If Yes, Give		. Was Decedent of I If Yes, specify Cub		specify Yes or No- to Rican, etc.)	Black, Wi	nerican Indian, nite, etc. White
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Σ	and and n 27 n 27 ner tre		Gloria B. Douglas	Daught			Street, 1	Baltimore,		
Baltimore,	or of H		20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ R	emoval from Stat	20b. Place of Dis	position (Name or ematory or other pla undel	ice)	Date 2	0c. Location - City	or rown, State
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O.	the a	/sic	1 Yes 2 No	4∐Pregnant 9□ Unknown		5□ Other (specify) _				
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•	-		30. Name and address of person who co	Malk	f death (Item 23a) (Typ	DY0	1010		Tarch 10	0,0000
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State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No: 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician MARCH 9, 2006 5:00 AM VIRGINIA LEE FORMWALT /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Baltimore Towson Saint Joseph Medical Center 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Pay, Year, 7/30/1929 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** 1 M 2 F WEST VIRGINIA 212-42-9608 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a State 10b County 28a-f show in than "natural", or iteme 23a or 28a-f showing Medical Examinar must be notified at 1 TYes 2 No BALTIMORE MD PARKVILLE Directo 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 2823 EMERALD ROAD 21234 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. hours after 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: ≥ 3 X Widowed 4 □ Divorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education within 72 h (Specify only highest grade completed) BALTO. COUNTY BOARD other than College (1-4or 5+) Flementary/Secondary (0-12) OF EDUCATION 12TH GRADE CAFETERIA MANAGER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be fill ment of Health and Mental H lant: If Item 27 is marked other. ELIZABETH G. MCGRAW WILLIAM COOK 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) CHERI L. WYATT/DAUGHTER 3020 OAKCREST AVENUE BALTIMORE, MD Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 □XBurial 2 □ Cremation 3 □ Removal from State 5 permit. Page Department o Important: If any injury or QDGE. HILLENDALE, MD MORELAND MEM. PARK 3/13/2006 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, P.A. 21. Signature of Juneral Service Licenses 8521 LOCH RAVEN BLVD. TOWSON, MD 21286 Approximate Interval Between Onset and Death 25a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) CHRONIC OBSTRUCTIVE PULMONARY DISEASE **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed physicien and the burial-transit Due to (or as a consequence of): Box 68760, by Physician/Medical use as ettending for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 9 Unknown 23d. Date of delivery 3 Ectopic pregnancy Year Month Dav 4 Pregnant at time of death 5 Other (specify) ed by the e o 9☐ Unknown ت 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably ACUTE RENAL FAILURE Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 22 No DIABETES MELLITUS TYPE II 24a. Was an has 2 No 1 Yes Division of Vital To the Hospital or Attending Physician: After this certification, funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Certification: To Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 27 Manner of Death 1 Natural 2 Accident 5 Pending investigation М 1 ☐ Yes 2 ☐ No death. after death Director: 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide within 24 hours a To the Funeral C completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 06 D 37254 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DRAVE TOWSON MARYLAND 21204 I M ay, Year) 76 / 1 DSL Lity 32 Registrar's Signature 31. Date filed (Month, Day, M.D. MAR 1 3 2006 State Registrar

NIM Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 06-01703 Gloria Fry State of Maryland / Department of Health and Mental Hygiene [ 1- State Registrar Amend Item #4a Per Phy g853 3/13/06 JH Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name March 9 Day **Physician** Gy lor 2006 7:18 A M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 6536 Parnell Avenue Baltimore
der 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) If Under 1 Year Months Days 8. Date of Birth 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Year) Months Hours 1 M 2 F -18-42-4576 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10h County il Hygiene. other than "natural", or items 23e or 28e-f ehow vent, the Medical Examinar must be notified at 1 Yes 2 □ No Baltimore Funeral Director 10f Zip Code 10g. Citizen of What Country? 10e. Street and Number 6539 arnell avenue 21222 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Race - American Indian, Black, White, etc. 11 Marital Status 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 ☑ No Baltimore, Maryland 21215-0036 Specify: If Yes, Give Year or Dates: Completed by 3 ☐ Widowed 4 Doivorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) OWN Home Homemaker 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event 90cg. Be HELEN 2 DEPENICUICZ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Info ant's Name/Relationship (Type, Print) Rd. WILLOW Spring 20c. Location - City or Town, State MD 21222 SON 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 22. Name and Address & Facility 106 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Suneral D. A. Home, EUNERal dle W. TIOW Spring 1222 34 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Cordiorascular disease **Physician** disease or condition resulting in death) athe roscleratic /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine attending physician and for use as the burial-transit certificate be executed Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Dav 4☐Pregnant at time of death 5 ☐ Other (specify) o. been signed by the should be detached detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 has autopsy nis certificate h I director, page 2 No 1 Yes 1 ☐ Yes 2 No of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) At Scene Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No ဥ this 28a. Date of Injury (Month, Day Year) ieral Director: After thi 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 27. Manner of Death Certification; 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 6 To the Hospital within 24 hours a To the Funeral Completely filled Hospital 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier O.C.M.E.

State Registrar 31. Date filed (Month, Day, Year) MAR 1 3 2006

Uran

March 9, 2006

			For State Registrar	State of Mai		Departme <i>Certifica</i>			Mental Hy	giene	006	07522
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			Greater Baltimore				wson	T #11-4 0411			ltimore	
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Baltimore	permit. Pages 1 and 2 should be filed Department of Heelth and Menta Hygis Important: if Itam 27 is marked other eny injury or other treumatic event.		21. Signature of Funeral Service License	9					OL LEVI			
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ita	ilcian: Th certificete rector, pag	0	25. Was case referred to medical					26. Place of Deat	1 ☐ Yes		T Tes	2 NO
>	Physician: this certific al director,	To B	examiner?	ospital: npatient	t 2□ER/Ou	tpatient 3	DOA Oth	er: 4 ☐ Nursing Ho	ome 5□Res	idence 6	Other (Specia	fy)
on o	ding P h. After t	Certification:	27. Manner of Death  1 Natural 5 Pending investigation	28a. Date o Injury (Month, Day	Year) 28b.	lime of njury M	28c. Injur Wor	y at k? Yes 2 □ No	28d. Describe	how injury or	ccurred	
įš	f or Attend after death Director: /	fica	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injur	y - At home, fa			.00 2			lumber or Run	al Route Number,
ō	rs after si Dire	Cert	4  Homicide determined	building, etc.	(Specify)				City or To	own, State)		
	To the Hospital or Attending Ph within 24 hours after death. To the Funaral Director: After th completely filled in by the funeral	Medicai	29a. Certifier (Check only one)  Certifying Physical Examination	ician: To the best of er: On the basis of e and manner state	examination an	e, death occurr d/or investigat	ed at the tir ion, in my o	ne, date and place, pinion, death occur	and due to the red at the time	cause(s) and date and pla	d manner as s ace, and due t	stated. o the cause(s)
	To th withir To th	M	29b. Signature and title of certifier	<i>E</i> . 2			29c. Licens	e number		29d. Date s	igned (Marith,	Day Year)
	COT		1 / 1/2	7 mg				13476	/		78,	16
	D'		30. Name and address of person who could be seen and address of person who could be seen address.	npleted cause of dea	BC (tom 23a)	(Type, Print)	mDi	21204			,	
	Sta Registi		31. Date filed (Month, Day, Year)  MAR 1 3 20	32. Registrar	's Signature							
DH	HMH 17 Rev 1/2		MAR 1 3 20	06 Mesus	S. S.	MOGAL						

			1- State of Maryland / [ Registrar		rtment of H tificate of L		Mental Hygie Rag.	a uuu	07523
ý	Physicia		1. Decedent's Name (First, Middle, Last)  EDWARD LEONARD		FINK		2. Date of Death Month MARCH 4,	Day Year 2006	3. Time of Death 3:05 A M
	/Medic Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	Location of Death		4c. County of Death	
			CONTINUUM CARE  5. Social Security Number 6. Sex 7. Age (In yrs. last bir	rthday)	If Under 1 Year	SYKES\	/ ILLE 8. Date of Birth		CARROLL place (State or Foreign
	Funeral Director		104 005	Yrs.	Months Days	Hours Min.	AUG. 15, 1	916	NY
	and w		Usual Residence of Decedent         10a. State         10b. County         10c. City, Tow	m or Loc	ation				10d. Inside City Limits
	Maryli -f eho	tor			IMORE				1 ☐ Yes 2 No
	th the	Director	10e. Street and Number		10f. Zip Code		10g.	Citizen of What Cou	untry?
	death with the Maryland me 23a or 28a-f ehow		130 SLADE AVENUE #524			21208		Tata B	USA
	ter de	Funeral	11. Marital Status  1 □ Never Married 2 1 Married  1 □ Never Married 2 M Married  1 □ Never Married 2 M Mw I I	13. W	as Decedent of Hi Yes, specify Cuba	ispanic Origin? (S) n, Mexican, Puerti	pecify Yes or No- p Rican, etc.)	14. Race - Amer Black, White	
2000	filed within 72 hours after death with the Marylan Hygiene. ither then "naturel", or Itame 23a or 28a-f ehow ont, the Medical Expediment mark for notified at	by	1 □ Never Married 2 1 Married 1 1 1 Married 2 I No WWII I 1 Married 2 Married 1 Married 2 I Married 2 I Married 2 I Married 3 □ Wildowed 4 □ Divorced 5 □ Married 1 □ Married 2 □ No WWII No Wildowski	CE 1	☐ Yes 200 No	Specify:		Specify:	WHITE
ה ה	72 hours "naturel", edical Exe	ompleted	15. Decedent's Education (Specify only highest grade completed)	(Give k	ent's Usual Occupa and of work done of ONOT use retired	furing most of wor		b. Kind of Business/li	ndustry
7 7	y withir plene. r then	ошо	Elementary/Secondary (0-12) Coffege (1-4or 5+)	MANA		/	R	ETAIL	
ana	A 0 E	Be C	17. Father's Name (First, Middle, Last)			18. Mother's Nam	ne (First, Middle, Mai	den Sumame)	
<u>ya</u>	should be nd Menta marked imatic ev	To		FINK		ANNA			COHEN
<u> </u>	nd 2 st lth and 127 is n fraun		1.1.1.				ral Route Number, C.   - BALTIM		
e,	ges 1 and 2 should it of Health and Mer if Item 27 is marke or other traumatic		20a. Method of Disposition 20b. Place o	f Dispos	ition (Name of atory or other place	- 1		c. Location - City or T	
аппо	ment cant: If		LOGIDUNAL 2 Under Communication 3 Under Communication State		NS CEMET	ı	10/2006	OWINGS M	ILLS, MD
Dall	permit. Pages Depertment of I Important: If Its eny Injury or o		21. Signature of Funeral Service Licensee		Name and Address	3(	OL LEVINSO ROAD - PI		•
			23a. Part1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line.	not ente	r the mode of dyin	g, such as cardiac	or respiratory arrest,		Approximate Interval Between
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)		uc tove	Primon	ry Dis	6-1-6	Onset and Death
	Examiner		Due to (or as a consequence	of):					
	P #	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	ut):					
	be executed icien and burial-transit	Examin	Cause (Disease or injury that initiated events c. Due to (or as a consequence	of):					
2/00,	cate be executed physicien and the burial-transit	dical E							
0	rtificate ng physi as the l	യ	IF FEMALE:						
X O D	n requires that the death certificens signed by the attending to should be detached for use as	ian/M	23b. Was decedent pregnant  23c. If yes, outcome of pregnancy  1 Live birth 2 Fetal death		Ectopic pregnancy			23d. Date of deli- Month	very Day Year
- - -	the de y the a	Physici	1   Yes 2   No 9   Unknown 4   Pregnant at time of death 9   Unknown	5 🖵	Other (specify)				,
7	s that	by Pt	Part II. Dther significant conditions contributing to death but not resulting it	in the un	derlying cause give	en in Part f.	23e. Did tobac	co use contribute to	the cause of death?
ğ	equire sen sig ould b	ted t	Dementin			<del></del>	1 Yes	2 No 3 Pro	bably 4 Unknown
Records,	E 25	Completed					24a. Was an autopsy performed	prior to c	topsy findings available ompletion of cause of
VIIal	T ate	e Coi	25. Was case referred to medical			OO Disease of Dans	1 ☐ Yes 2 ☑		2 No
	Physician: this certific ral director,	0	examiner?  1 Tyes 2 No  Hospital: 1 Inpatient 2 ER/Or	utpatient	3 DOA Othe	4	th (Check only one) ome 5 - Residence	e 6 Other (Spec	ufy)
0	ding Phys J. After this funeral di	on: T		Time of Injury	28c. Injun World	at	28d. Describe how		
DIVISION	ttendi death. tor: A the fu	icatl	2 Accident investigation 3 Suicide 6 Could not be			Yes 2□No	294 Location /Street	et and Number or Ru	ral Cauta Numbar
2	after Direct din by	Certification:	determined  4 Homicide  determined  28e. Place of Injury - At home, fa	aitti, stie	et, factory, office		City or Town, S		an riodie riditaer,
	To the Hospitel or Attending Ph within 24 hours after death. To the Funarel Director: After th completely filled in by the funeral	edical C	29a. Certifier (Check out) one)  1 Certifying Physician: To the best of my knowledge 2 Madical Examinar: On the basis of examination ar and manner stated.	e, death	occurred at the tin estigation, in my of	ne, date and place pinion, death occu	, and due to the caus rred at the time, date	se(s) and manner as and place, and due	stated. to the cause(s)
	To the within To the comple	Me	29b. Signature and title of certifier		29c. Licenso	number	29d.	Date signed (Month	i, Day, Year)
	- 1		Mora J. Mon, MO		0.	1500	3	104/0	) 6
1	5		29a. Certifier  (Check only one)  2   Madical Examinar: On the best of my knowledge and manner stated.  29b. Signature and title of certifier  30. Name and address of person who completed cause of death (Item 23a)  31. Date filed (Month Par Year)  32. Signature	(Туре,	Print)	Cart.	Prive	Reinfran	four, MI.
-0	Sta Registr		31. Date filed (Months Ray Year) 3 2006 32. Egistrar's Signature	A	and a				
			7	(61.6A)					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Dav Year **Physician** William Green 6:40 P. M 2006 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Joseph Richey Birthplace (State or Foreign Country) If Under 24 Hrs. If Under 1 Year 7. Age (In yrs. last birthday) 6. Sex 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** Days Min Months Hours 1**∑**M 2□F 250-42-9785 77 Yrs. Director 2-12-1929 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County rthen "natural", or Itame 23a or 28a-f ehow the Medical Examinar must be notified at 14 Yes 2 No N/A Balto Md Direct 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21229 USA 4232 Colhorne Road Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Black 1 ☐ Yes 2 No Specify: Maryland 21215-0036 Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) High Grade Meat Packing Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Butcher Company permit. Pages 1 and 2 should be filled.
Department of Heelth and Menial Hygis
Important: If Item 27 Is marked other 1
eny Injury or other traumatic event, Ite.
2006. 10th grade and Mental Hygie 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Cub Green Hattie Green ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Linda Green - Daughter 3203 Burleith Avenue Balto, Md 21215 Baftimore, 20b. Place of Disposition (Name of cemetery, crematory or other p 20c. Location - City or Town, State 20a. Method of Disposition
1 ☐Burial 2 ☐ Cremation 3 ☐ Removal from State King Memorial Park 3-13-2006 Randallstown, Md 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March F/H West 4300 Wabash Avenue Balto, Md 21215 Jam pach ther the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heert failure. List only one cause on each line. Approximate Interval Between 23a. Part1. € Onset and Death Immediate Cause (Final UREMIA Physician disease or condition resulting in death) /Medical NEPHRO PATHY Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of deliven 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 ▼ No 24a. Was an autopsy performed 1 Yes 28 No certificete Attending Physician: 26. Place of Death | Check only one 25. Was case referred to medical Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 EP/Outpatient 3 DOA Medical Certification: To 1 ☐ Yes 2 ♥ No 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No death. investigation Director 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide hours after ö To the ...
within 24 hours
To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certitier (Check only one) 29c. License number 29d, Date signed (Menth, Day, Year, 29b. Signature and title of certifier

State Registrar

DHMH 17 Rev 1/2001

1425 BOLTON ST BALTIMORET, MD 21207

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Pagistrar's Signature

1. HORDWITZ

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** URNE 00:45 AM MARCIT 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTMORE CONTH WEST NACCSTOU If Under 1 Year | If Under 24 Hrs. | 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Days Hours 1□M 2 F 170-10**-**3211 87 Director Jan.27,1919 Pennsylvania Usual Residence of Decedent with the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumatic event, the Mudical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Funeral Director Maryland Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6441 Clifton Forge Circle 21228 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No Specify: þ Specify: 3 → Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 10th Grade Homemaker Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Giuseppe Angelini Maria Quite ၉ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6441 Clifton Forge Circle/ Catonsville, Md. 21228 Edward J. Gurney/ Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Italian-American Cem. Mar. 15,2006 Scranton, Pennsylvania 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Baltimore, Denald K. Watson, Leonard J. Ruck, Inc. 5305 Ha

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Lonald R. ) Leonard J. Ruck, Inc. 5305 HarfordRd. Md. 21214 Approximate Interval Between Onset and Death **Physician** /Medical Examiner burial-transit

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director.

Baltimore, Maryland 21215-0036

	disease or condition resulting in death)	a. NYOCACIIIA	16 INFARC	TION		
Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of).  c  Due to (or as a consequence of):				
Completed by Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown		pic pregnancy er (specify)		23d. Date of de Month	livery Day Year
ed by Pr	Part II. Other significant conditions of	ontributing to death but not resulting in the underly	ying cause given in Part I.	23e. Did tobacc		o the cause of death? robably 4 Junknown
Complet				24a. Was an autopsy performed 1 Yes 2	death?	utopsy findings available completion of cause of
Be	25. Was case referred to medical examiner?			ath (Check only one)		
မ	1 ☐ Yes 2 € No			Home 5 Residence	6 ☐Other (Spe	ecify)
atlon	27. Manner of Death 1 ☐ Matural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Time of Injury	28c. Injury at Work? 1 Tyes 2 No	28d. Describe how in	jury occurred	
Certific	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, farm, street, f building, etc. (Specify)	actory, office	28f. Location (Street City or Town, St	and Number or R ate)	ural Route Number,
Medical Certification:	29a Certifier 1 Certifying Ph (Check only 2 Medical Examone)	ysician: To the basis of my knowledge, death occupinar. On the basis of examination and/or investigand manner stated.	urred at the time, date and plan pation, in my opinion, death occ	and due to the nause urred at the time, date a	(s) and manner a and place, and due	s stated. e to the cause(s)
ž	29b. Signature and title of certifier		29c. License number	29d. [	Date signed (Moni	th, Day, Year)
	1	MP	D57722		trett 11	2006
	LEDYARD RICHARDSON	S401 OLD COURT ROAP, RA	10.0			
ite	31. Date filed (Month, Day, Year)	32. Registrar's Signature				
ar	MAR 1-3 2008	See A Sparke				
001						

Sta

Registrar

CPM 06-01545 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Unpenditem#23a,27,28a-f, pende,0853,3/18/06 TT State of Maryland / Department of Health and Mental Hygiene Michael Gee 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death March Physician ďŽ, MICHAEL 14:35 Cour /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Bon Secours Hospital Baltimore Na Months Days Hours Min. 8. Oate of Birth (Month, Day, Year)

August 1, 190 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 10 M 2□F 213 80 7359 Yrs. Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits "naturel", or items 23a or 28a-f ehow r then "naturel", or items 23a or 28a-f ehor the Medical Examiner must be notified at 1 Yes 2 No Directo MID BATHIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1510 W. Musher 2/217 UISA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: filed within 72 hours after 1 ☑ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 Specify: Black 1 Yes 2 4No Specify: þ 3 □ Widowed 4 □ Oivorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Oecedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) WULKED NEVER permit. Pages 1 and 2 should be filed to Department of Health and Mental Hygie Important: If item 27 is marked other to eny injury or other traumatic event, the once. 10 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Be Clifton Buston MildREd Ger ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MILDRED Matthews Bastimone 1316 W. MUSher MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 3/1106 4 ☐ Donation 5 ☐ Other (Specify) DAHMURE 21. Signature of Funeral Service Licensee 22. Name and Address of Facility BLHS Funeral Hemo Patricia 1129 N. CARVINE St BASTAMURE FAD But 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Cocaine, heroin, and ethanol intoxication /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours attended.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of) P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy Month Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Oid tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

Yes 2□ No 24a. Was an autopsy performed? 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 1X Yes 2 □ No 28a. Date of Injury (Month, Day Year) Fnd3/2/2006 28c. Injury at Work? 27. Manner of Oeath 28b. Time of 28d. Oescribe how injury occurred Fnd 2:15 P 1 Natural 5 Pending 1 ☐ Yes 2 No 2 Accident investigation unk 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1045 N. Fulton St. 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 🗍 Homicide found in house Baltimore, MD 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier March 03, 2006 O.C.M.E. Inemuk 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Pollakun 111 Penn Street, Baltimore, Maryland 21201

DHMH 17 Rev 1/2001

State Registrar

ATRIGIA 31. Date filed (Month, Day, Year)



32. Registrar's Signature

		1	For Amend I	tem State	of Maryla	893,000 Ce	artment of rtificate	Healt of Dea	h and M	Mental Hy	giene) () Reg. No.	06	07527
200			Decedent's Name (First, Middle							2. Date of De. Month		Year	3. Time of Death
	Physicia		Patricia	Lee	Gracie		C-,-	ع دعدد		March 1	-		11:25 p <sup>M</sup>
)	/Medic Examin		4a. Fecility Name (If not institution,	give street and i	number)		4b. City, Tov	wn, or Locati	ion of Death	1	4c. Count	y of Death	
			11833 Heatherfi	eld Trai	i.1			larket				deri	
Ŕĵ	Funeral Director		5. Social Security Number 231–54–1655	6. Sex 1 ☐ M 2 🔼 F		rs. last birthday Yrs.	If Under 1 Y Months D		irs Min.	8. Date of Bir (Month, Da Sept. 7	v. Year)	Cou	plece (State or Foreign intry) orado
	pu ,	-	Usuel Residence of Decedent 10a, State 10b, County		10c	City, Town or L	ocation						10d. Inside City Limits
	anyla shov	-											1 ☐ Yes 2 ☒No
	Asa-1	Director	Maryland Freder	ick	N	ew Mark	10f. Zip Co	ode	· · · · · · · · · · · · · · · · · · ·		10g. Citizen of	What Cor	untry?
	with t		11833 Heatherfi	old Tra	<b>1</b> 1			L774			USA		
	s 23	Funerai	11. Marital Status		ecedent Ever in	n U.S. 13.	-	· · · ·	c Origin? (S	pecify Yes or No o Rican, etc.)	- 14. Ra		ican Indian,
	Item	ü	1 □ Never Married 2 □ Marri	Armed	Forces?					o Rican, etc.)		ack, White	
99	Ir. or	by	3 ☐ Widowed 4 ☑ Divorced	If Yes,	Give r Dates:		1□Yes 2⊠	☑No Spe	эсту:		Spec	ry: W	hite
ŏ	2 hou	ted	15. Decedent	's Education	ad)	16a. Dec	edent's Usual C	Occupation	most of wo	rking	16b. Kind of	Business/I	ndustry
2	Pin 7	pie	Elementary/Secondary (0-12)	T	e (1-4or 5+)	life.	DO NOT use	retirea)				. 1 0	
7	ad with	Completed	12				A	Analis		me (First, Middle			ecurity
2	al Hy al Hy al oth	Be (	17. Father's Name (First, Middle,		D			18. N	Virg		, Maiden Sum	Wood	
<u>yla</u>	Ment Ment arke	ဥ	George	н.	bru	mble				ural Route Numb	as City as Tau		
a	and and is m		19a, Informant's Name/Relations									1, 31410, 2	ip code)
2	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. itsm 27 is marked other than "natural", or Items 23s or 28s-1 show other traumatic event, the Madical Examinar must be nutified at other traumatic event, the Madical Examinar must be nutified at		James D. Gracie	(Son)	20	b. Place of Disp	Longbow	N Rd	Mt.	Airy, MI Date	20c. Location	- City or	Town, State
O	ges to H of H		20a. Method of Disposition  ∏☐ Burial 2 ☐ Cremation			cemetery, cr	ematory or other	er place)	1			ore.	Maryland
Ē	t. Pa tmen tant: sjury		<ul> <li>4 □ Donation 5 □ Other (S</li> <li>21. Signature of Funeral Service</li> </ul>		14	oudon 1	22 Name and	Address of F	acility LO	udon Par	k Fune	ral H	ome
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 Department of Health s Important: If itsm 27 li any injury or other tra 2002.		1				3620 Wi	ilkens	Ave.	, Baltin	nore, M		29
	Physician		23a. Part Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition	only one cause	on each line.	death. Do not e					ırrest,		Approximate Interval Between Onset and Death
S.	/Medical Examiner		resulting in death)	Due	to (or as a con	nsequence of):	ion z l-v	156	nsas	>			4 000
	₩. #.	Iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due	to (or as a cor	nsequence of):			. /				2,540
	ate be executed nysician and he burial-transit	Examiner	that initiated events resulting in death) Last	c	to (or as a con	guance of):	16-	17.	7100.	7000			2,397
760,	be exician buria	cal E									<u></u>		
687	ficate phys s the			u									
Box (	leath certificate attending phy I for use as the	N	IF FEMALE: 23b. Was decedent pregnant		outcome of prove		B⊟Ectopic pred	anancy				Date of de	The second secon
.O. Be	the the	Physician/Med	in the past 12 months? 1 ☐ Yes 2 ☐ 100 9 ☐ Unknown	4□P	regnant at time		☐ Other (spec					Month	Day Year
0	uires that the signed by detaction	by Pr	Part II. Other significant conditi	ons contributing	to death but no	t resulting in the	underlying cau	use given in	Part I.				the cause of death?
rd	w require been sig should b	ed									Yes 2		
Records,	e law re has be ge 2 sho	Completed									s an 24 opsy formed?	prior to death?	utopsy findings available completion of cause of
Œ	The I	NO.								1 ☐ Yes			2 □ No
Vital	ician: The certificate rector, pag	Be (	25. Was case referred to medical examiner?					0.1		eath Check on			
	Physician: this certificant	2	1 Yes 2 No			2 ER/Outpat		- Commence	Nursing	Home 5 He	idence 6 🖂		ocify)
ū	fer fer		27. Manner of De th 1 Natural 5 ☐ Pendi	9	Date of Injury Month, Day Ye	ar) 28b. Time Injur	9 OT 28 Y M	Bc. Injury at Work? 1 ☐ Yes	2 □ No	280. Describe	TIOW IIIJULY OC	direc	
sio	death.	cati	Accident invest	not be	Name of Injury	At home, farm,			20110	28f. Location	(Street and Nu	mber or R	ural Route Number,
Division of	st or Attending after death. I Director: Afte d in by the fune	Certification;	4 Homicide determ	nin ad   200. F	viace of injury - building, etc. (S	pecify)	street, factory,	onice			own, State)		
	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director.	Medical C	29a. Certifier 1 Certifyi (Check only 2 Medica	ng Physician: T I Examiner: On t and	o the best of my he basis of exa manner stated.	mination and/or	eath occurred a investigation, i	it the time, di	ate and place n, death occ	ce, and due to th curred at the time	e cause(s) and e, date and place	manner a e, and du	s stated. e to the cause(s)
	o the o the omple	Mec	29b. Signature and title of certifi					License nur				-	th, Day, Year)
	F S F Ö		12	2,	Ma	75		1014	162	<i>C</i>	Ma.	and the same	2,2000
	((0))		30. Name and address of person	who completed	cause of death	(Item 23a) (Ty	oe, Print)						2,200C
			0795	1700:	sch.	MP	501	wi	7 63	51-	F-120	17	9 190
		ate	31. Date filed (Month, Day, Yea	00	32. Registrar's	Signature	in the same						
	Regis	trar	MAR I 3 ZU	UD ACC	April Sul	1	6.						

DHMH 17 Rev 1/200†

			For	State of Marylan				•	iene	· · · · · · · · · · · · · · · · · · ·
		Í	1 - Stata Registrar		Certi	ificate of E	Death	Re	g. No. U U b	0/528
	Physici	20	1. Decedent's Name (First, Middle, La					2. Date of Deat Month	h Day Yea	3. Time of Death
	/Medic		HOWARD .	: HAYDEN				March	9 2006	2026 M
	Examin	ier.	4a. Facility Name (If not institution, giv		4		Location of Death		4c. County of De	
		47	292 CANTER 5. Social Security Number 6.5		last hirthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	HARFO	
Ŀ	Funeral Director		218-28-5898	20 F 73		Months Days	Hours Min.	Month, Day,	Year)	Birthplace (State or Foreign Country)
	and		Usual Residence of Decedent  10a. State 10b. County	10c. Cit	y, Town or Loca	ition				10d. Inside City Limits
	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or Itame 23s or 28s-f ehow or other traumatic event, the Medical Exeminal multiple inclined at	Director	MD HART	ERD.	4.	Belair				1 ☐ Yes 2 No
	if th	Dire	10e. Street and Number	i		10f. Zip Code	7	11	0g. Citizen of What	,
	23a	- a		REURY RD			1014		U.S.	
	itam Itam	by Funeral	11. Marital Status  1 Never Married 2 Marned	12. Was Decedent Ever in U Armed Forces?	.S. 13. Wa	as Decedent of His res, specify Cubar	spanic Origin? (Sp n, Mexican, Puerto	ecity Yes or No- Rican, etc.)	14. Hace - Ai Black, W	merican Indian, hite, etc.
920	urs af	by F	3 Widowed 4 Divorced	If Yes, Give Year or Dales: A	10	Yes 2 No	Specify:		Specify: L	chiTe
215-0036	72 ho	Completed	15. Decedent's E (Specify only highest gra	ducation	16a. Deceder	nt's Usual Occupa	ition furing most of work	vina	16b. Kind of Busine	ss/Industry
21	thin 7	nple	Elementary/Secondary (0-12)	College (1-4or 5+)	life. DC	O NOT use retired)	)		_	
2	filed with Hygiene other tha	ပို	12+4	NIA	T.	Pe FIT				Teele CORP.
and	ould be fi Mental H arked otl atic ever	Be	17. Father's Name (First, Middle, Last,	naypen			18. Mother's Name	_		
Maryland	d Me d Me mark matic	2	HOWARD . H . /2  19a. Informant's Name/Relationship (		19h Mailing			REUA.	City or Town, State	Zin Code)
Ma	nd 2 sho lift and 27 is mu		FRANCES HAY		_		bury RL			21014
ē,	s 1 and f Health item 27 other tr		20a. Method of Disposition	205. [	Place of Disposit	tion (Name of		Date	20c. Location - City	or Town, State
Baltimore	Pages nent of int: if its iry or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specil	Removal from State	PlAIR	Comité R	4 3/14	1/06	Belain	MS.
alti	permit. Page Department o Important: If any Injury or once.		21. Signature of Funeral Service Lice		22	Name and Addres	s of Facility	DIAL HOM	e PA	
ω_	88558		faul M.	Stella	75	27 harfor	LO RO. B	alto M	e, PA 0 21239	/
7			23a. Part1. Enler the disease, or com shock, or heart failure. List only	plications that caused the deal one cause on each line.	h. Do not enter	the mode of dying	g, such as cardiac	or respiratory arre	est,	Approximate Interval Between
100	Physician		Immediate Cause (Final disease or condition resulting in death)	aA	Shes 16	Sig				Onsel and Death
	/Medical Examiner		resulting in death)	Due to (or as a consec	juence of):					,
		-	Sequentially list conditions, if any, leading to immediate	b	juence of):					
/	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	·	,					
oʻ	be executed iclen and burial-transit	Exa	resulting in death) Last	Due to (or as a consec	juence of):					
3760,	e ys	cal	•	d						
x 68	e as t	Med	IF FEMALE:							
Box	ath cattend	lan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregn. 1 Live birth 2 Feta	ıl death 3 □E	ctopic pregnancy			23d. Date of Month	delivery Day Year
P.O.	the de	yslc	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time of d 9□Unknown	ieatn 5∐C	Other (specify)				
	The law requires that the death certificate be executed sie hes been signed by the attending physicien and page 2 should be detached for use as the burial-transit	by Physician/Med	Part II. Other significant conditions	ontributing to death but not res	ulting in the und	lerlying cause give	en in Part I.	23e. Did tol	pacco use contribute	to the cause of death?
Records,	w require been sig should b							1 □ Ye	s 2 No 3	Probably 4 Dunknown
ဝင္ပ	law re Bs be 2 sho	Completed						24a. Was a autops		autopsy findings available to completion of cause of
E E		Con						perforr	ned2 death	
Vital	ician: ertific ector,	Be	25. Was case referred to medical examiner?	Hospital:		104	26. Place of Deat			
of	Physician: this certific ral director,	10	1 Yes 2 No 27. Manner of Death	1 Inpatient 2	ER/Oulpatient 28b. Time of	3 DOA	4 Nursing Ho		ence 6 Other (S	pecify)
O	ding h. After fune	tlon	Natural 5 Pending 2 Accident investigatio	(Month, Day Year)	Injury	28c. Injury Work	res 2 □ No	200. Describe no	w injury occurred	
Division	Attending r deeth.  •ctor: After by the funer	flca	3 ☐ Suicide 6 ☐ Could not b	e 28e. Place of Injury - At h	ome, farm, stree					Rural Route Number,
ā	s afte	Certification:	4  Homicide determined	building, etc. (Speci	<b>(y</b> )			City or Towr	n, State)	
	To the Hospital or Attendi within 24 hours after deeth.  To the Funeral Director: A completely filled in by the fu	Medical (	29a. Certifier   Certifying Pl (Check only one) 2   Medical Example	niner: On the basis of examination and manner stated.	owledge, death o ation and/or inve	occurred at the limestigation, in my op	ne, date and place, pinion, death occur	and due to the carred at the time, d	ause(s) and manner ate and place, and c	as stated. due to the cause(s)
	o the	Mec	29b. Signature and Wie of certifier		During 1	29c. License	number	2	9d. Date signed (Mo	onth, Day, Year)
	- s = ō		Von t	w Let	*	1	28136		7 10	
	0 -		30. Name and address of person who	completed cause of death (Itel	n 23a) (Type, Pr	rint)	7		<i>y</i> '	
	1771		Robert A. Duncar		1. MAC	cphail R	S. Bela	in MS	21014	
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Sign	ature					
100	Regist	rar	MAR 1 3 2	NOS Alamana	K da	rate 1				

			State of Maryland / Dep	artment of Heal		ental Hygie	ZIIIIh	07529
		#	Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day_ Year	3. Time of Death
10	Physicia /Medic	_	Thelma A. Hartlove			February	27, 2006	10:30 P <sup>M</sup>
	Examin	er	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Loca			4c. County of Death	
12cm			2512 Wilkens Avenue  5. Social Security Number 6. Sex 7. Age (In yrs. last birthda)		timore Under 24 Hrs.	O. Data of Righ	N/A	-1 (0:
4	Funeral Director		219-12-9737 1 M 2 F 94 Yrs.		ours Min.	8. Date of Birth (Month, Day, Y Aug. 22,	1911 V	place (State or Foreign intry) irginia
	7		Usual Residence of Decedent					
	arylar	_	10a. State 10b. County 10c. City, Town or t					10d. Inside City Limits
	8a-f	ecto	N/A	Baltimore				1 X Yes 2 □ No
	72 hours after death with the Maryland naturel; or iteme 23e or 28e-f ehow licel Evel. Let must be calified at	Funeral Director	10e. Street and Number 2512 Wilkens Avenue	10f. Zip Code	223	10g	Citizen of What Cou	•
	leath ne 23	erai				cify Yes or No-	United St	
(0	r iten	Fu	1 Never Married 2 Married 1 Yes 2 No	Was Decedent of Hispan If Yes, specify Cuban, Me		Rican, etc.)	Black, White	etc.
036	rei', o	by	3 ⚠ Widowed 4 □ Divorced If Yes, Give Year or Dates:	1 ☐ Yes 2 🗖 No Sp	pecify:		Specify:	White
21215-0036	72 h	Completed	(Specify only highest grade completed) (Giv	edent's Usual Occupation work done during	g most of workin	16	b. Kind of Business/li	ndustry
121	ne. hen	mpi	Elementary/Secondary (0-12) College (1-4or 5+)	DO NOT use retired)  Homemaker			Own 1	Jamo
	Hygie ther t		17. Father's Name (First, Middle, Last)			(First, Middle, Mai		nome
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Department of Health and Mental Hygiene.  Brownstant: If item 27 is marked other than "neture;" or items 23s or 28s-f show eny injury or other traumatic event, it a Mudical Exact institute that items and itself at an injury or other traumatic event, it a Mudical Exact institute that items and itself at an injury or other traumatic event, it and items are also and items and items are also and items and items are also an are also and items are also and i	To Be	Gordon Brown			e Gibson		
ary	shound M	-		ing Address (Street and N				p Code)
	alth a alth a 27 is		Naomi Morris Daughter 22C	Deer Run Cou	ırt, Hal	ethorpe,	MD 21227	
Baltimore,	of He of He fiter r oth		20a. Method of Disposition  1	osition (Name of omatory or other place)	Da	ate 20	c. Location · City or T	own, State
Ĕ	Pag ment ant: i	1	4 Specify Memorial	Park	3-3-20		Glen Burn	
3alt	Depart Import eny inj once.	1		2. Name and Address of I				
	a □ = • a	V		719 Hammonds				
H			23a. Part1. Enter the disease, or complications that caused the death. Do not enshock, or heart failure. List only one cause on each line.	ter the mode of dying, suc	ich as cardiac or	respiratory arrest		Approximate Interval Between Onset and Death
120	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Clast of	taill	ire		
	Examiner		Due to (oray a consequence of):	tic card	in Visco	ulas Di	Lana	
		er		tic colla	20 .00		recre	
	cuted	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	nscem				
Ó,	cate be executed oblysicien and the burial-transit		resulting in death) Last Due to (of as a consequence of):					
8760,	hysic the b	dicai	d					
Box 6	ding ph	Physician/Med	IF FEMALE: 23c. If yes, outcome of pregnancy					
	atten for u	cian	in the past 12 months?	□Ectopic pregnancy □ Other (specify)			23d. Date of delive Month	ory Day Year
P.0.	that the death certift ed by the attending detached for use as	ysic	1 Yes 2 No 9 Unknown 9 Unknown					
	law requires that the death certific as been signed by the attending pl 2 should be detached for use as t	by Pi	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in	Part I.	23e. Did tobac	co use contribute to	the cause of death?
īg	w require been sig should b	edr	Hypothyrojdym			1 ☐ Yes	2 No 3 ☐ Pro	bably 4 □Unknown
Division of Vital Records,	e law re has bec je 2 sho	Completed				24a. Was an autopsy	24b. Were aut	opsy findings available
œ —		E O				performed	d? death?	2 No
/ita	ifcien: Th certificate rector, pag	Be (	25. Was case referred to medical examiner?		Place of Death	(Check only one)		
of/	Physic this c	2	1 ☐ Yes 2 🕱 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatie  27. Manner of Death   28a. Date of Injury   28b. Time				e 6 Other (Speci	fy)
ng	Attending Physicien: The r death. ector: After this certificate h by the funeral director, page	tion	1 Natural 5 Pending (Month, Day Year) Injury	of 28c. Injury at Work?  M 1 □ Yes		8d. Describe how	intury occurred	
isi	deat ctor: y the	fica	3 Suicide 6 Could not be			8f. Location (Stree	et and Number or Rur	al Route Number.
Š	after after I Dire	Certification:	4 ☐ Homicide determined building, etc. (Specify)	,,		City or Town, S	State)	
)	To the Mospitel or Attending Ph within 24 hours atter death. To the Funerel Director: After thi completely filled in by the funeral		29a. Certifier (Check only 2   Medical Examiner: On the basis of examination and/or in the basis of examination and exam	th occurred at the time, da	ate and place, a	nd due to the caus	se(s) and manner as	stated.
	the H nin 24 the Fi nplete	Medical	one) and manner stated.					
	with To	2	29b. Signature and title of certifier	29c. License num	mber	29d.	Date signed (Month,	Day, Year)
}	0			W 216	647	F	exinary	28,2006
	1		30. Name and address of person who completed cause of death (Item 23a) (Type	Print) WINIXTE	NS AI	- RAI	TIMOR E	MD 21228
C.	Sta	te	29b. Signature and the of certifier  30. Name and address of person who completed cause of death (Item 23a) (Type SAY BANDAY BAS KARAN 345)  31. Date filed (Month, Day, Year)  MAR 1-3 2006	) VILUL	710	1	-j ir-iqc b .	
	Registr	-11	MAR 1 3 2006	A CONTRACTOR OF THE PARTY OF TH				

			1 - For State Registrar	State of Ma	arylan	-	rtment of F	lealth ar	nd Mer	ntal Hygie	•	07530
	Physici /Medic		1. Decedent's Name (First, Middle Alice Elizabe	eth Johnso	n					Month Arch, 6	,2006 Year	3. Time of Death 7:00 AM
	Examin	er	4a. Facility Name (If not institution, 4919 Herring	Run Drive			4b. City, Town, o Baltimo	ore			4c. County of Dea	N/A
f	Funeral Director		215-16-9458	6. Sex 7. Ag 1 ☐ M 2 🖾 F	e (In yrs. I 5	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hours	4 Hrs. 8. Min.	Date of Birth (Month, Day, Y 20,23,	9. Bir	thplace (State or Foreign puntry) MD
Paclacia	a-f show	tor	Usual Residence of Decedent  10a. State 10b. County  MD	N/A	10c. City	y, Town or Lor Ba	cation altimore	9				10d. Inside City Limits 1 □XYes 2 □ No
h with the	23a or 28 at be not	Funeral Director	10e. Street and Number 4919 Herring	Run Drive			10f. Zip Code	1214		100	J. Citizen of What Co	untry? USA
OSO West deet	el', or iteme 2	þ	11. Marital Status  1 Never Married 2 Marrie 3 Never Married 4 Divorced	12. Was Decedent Armed Forces? ad 1 Yes 2 14 If Yes, Give Year or Dates:			Vas Decedent of H Yes, specify Cuba	lispanic Originan, Mexican, I	in? (Specify Puerto Ric	y Yes or No- an, etc.)	14. Race - Ame Black, Whit Specify:Bla	te, etc.
III & I & I & I S-0000	Depertment of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel", or iteme 23a or 28a-1 show any injury or other traumatic event, the Medical Examinat must be notified at once.	Completed	15. Decedent (Specify only highes Elementary/Secondary (0-12) 11 t.h	s Education t grade completed) College (1-4or 5	5+)	(Give	lent's Usual Occup kind of work done DO NOT use retired Or Chef	ation during most o	of working		Black &	
ylallu ylallu	Mental Hy Marked oth Matic event	To Be (	James Mitche	ll Barnes	Sr.			Kat	ie		uiden Sumame)	
, INICI	ealth and m 27 ie m		19a. Informant's Name/Relationsh Linda Wilson			4332	Mary H		Driv	ve Bal	city or Town, State, . timore N	4D 21133
Daltillore	ment of H ent: If ite ury or otl		20a. Method of Disposition  1 Surial 2 Cremation 4 Donation 5 Other (Sp.		C	emetery, crem	sition (Name of natory or other place Valley	Cem 3	Date 3/11,		imonium	
ם ב	Depert Import any in		21. Signature of Funeral Service L	aconsoo Auris		1	Name and Addre 240 Rei:		Ciia	tman-H Rd Ba	arris Fu ltimore	neral Homo MD.21215
	hysician /Medical xaminer		23a. Part 1 Enter the disease, or shock or heart failure. List of Immediate Cause (Final disease or condition resulting in death)	a	le	m		ng, such as ca	ardiac or re	espiratory arres	t.	Approximate Interval Between Onset and Death
roo,	physicien and	Ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b								
The law requires that the death conflicts he evented	signed by the attending phy d be detached for use as th	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1	2 Fetal	death 3	Ectopic pregnancy Other (specify)	,			23d. Date of de Month	livery Day Year
r do, r	been signed b	Š	Part II. Other significant condition	ns contributing to death b	ut not resu	ulting in the ur	nderlying cause giv	en in Part I.		23e. Did toba	. /	o the cause of death?
ai The laws	After this certificete hes be tuneral director, page 2 sh	Completed							_	24a. Was an autopsy performe	prior to	utopsy findings available completion of cause of
Physician:	nis certi	To Be	25. Was case referred to medical examiner?  1 \( \text{Yes} \) 2 \( \text{No} \)	Hospital:	ent 2 🗆	ER/Outpatien	t 3□ DOA Oth	Ar.		5 Residen	ce 6 ☐Other (Spe	icify)
	eath. or: After th	atlon:	27. Manner of Death  1 Natural 5 Pending 2 Accident investig	ation	ry y Year)	28b. Time of Injury	28c. Injur Wor M 1	yat k? Yes 2 □ No		. Describe how	injury occurred	
	within 24 hours efter death.  To the Funeral Director; After completely filled in by the fune	Certific	3 Suicide 6 Could n 4 Homicide determi	ned 28e. Place of Inj building, et	c. (Specify	<i>(</i> )	eet, factory, office			City or Town,	·	
H ed	within 24 hours To the Funeral I	ledical	one)	Physician: To the best examiner: On the basis of and manner sta	l examin <i>a</i> l	wledge, death tion and/or inv	restigation, in my o	pinion, death	place, and occurred a	at the time, date	and place, and due	e to the cause(s)
,	To	Σ	29b. Signature and title of certifier	Moo	-	mo	29c. Licens		187		I. Date signed (Mont	
0	71		30. Name of address of person v	who completed cause of d	eath (Item	23a) (Type,	Print) RAUEN	821	עע	BALT	imore	mp 21739
	Sta Registr		31. Date filed (Month, Day, Year)	32. Pågistr	ar's Signa	ture	and a					

State of Maryland / Department of Health and Mental Hygiene 11 11 5 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Yeer **Physician** Eva Stevens Johnson March 5, 2006 2:00 p /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Cockeysville

| If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | 12-15-1915 300 International Circle Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1□M 2□√X 216-14-8004 90 Yrs. Virginia Director Usual Besidence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits •how r than "neturel", or iteme 23a or 28e-f ehov the Madical Exeminer must be nutified at MD Baltimore 1 ☐ Yes 2☐No Cockeysville Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 300 International Circle 21030 U.S.A. Funerai 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: Specify: White þ 3 ➡Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Calvert Distillery Bottling 12 other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be fill ent of Health and Mental Hint: if item 27 is marked othry or other traumatic eventy Richard Stevens Loureese Rowe 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Vernon Johnson, Jr./Son 708 West Baker Ave. Abbington, MD 21009 20b. Place of Disposition (Name of cemetery, crematory or other place)

Glebe Landing Baptist
Church Cemetery permit. Pages 1
Department of He
Important: if iten
any injury or oth 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☑ Removal from State Laneview, Va. \* 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Ambrose Funeral Home of Lansdowne 2719 Hammonds Ferry Rd. Lansdowne MD 23a. Pan 1. Enter the disease or complications that caused the leath. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. ongestive Dewit Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Cardo mopatar Sequentially list conditions, I any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Dualto for as a consequence of: The law requires that the death certificate be executed physician ar s the burial-tr Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical as attending p IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ A Desselvita Voscilar Strube 1 ☐ Yes 2 ☐ No 3 Probably Completed page 2 should 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? has autopsy performed? 210 No certificate 2JP No 1 Yes 1 Yes Be 25. Was case referred to medical examiner? director, 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No ဥ 3 DOA After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification; 28d. Describe how injury occurred 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28l. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide fo to.
within 24 hou.
the Funeral D Leg Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 3-6-06 21464 , Ms. who completed cause of death (Item 23a) (Type, Print) Bank ST Beelto, Mil Z 12 24 , MO. ROBERT 32 Registrar's Signature State Registrar

Amend item#10a,perPil, 2853,3/13/06 TI State of Maryland / Department of Health and Mental Hygiene 1- State Registramend Item #9&10f Per FH G853 Cartificate of Peath 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Yee **Physician** 3:20 A M Charles Albert Kyle 10 2006 March /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** Joseph Richey Hospice Baltimore tf Under 1 Year | tf Under 24 Hrs. 6. Sex 1 M 2 □ F 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Yrs 74 <del>labama</del> Florida 265-36-9338 Director 05/08/1931 Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits r 28a-f show 1 Yes 2 No Director Maryland Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? rthen "natural", or itema 23a or the Medical Examinar must be 20012 20018 7440 Georgia Avenue N.W. U.S.A. death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 XYes 2 No 1952 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: Black Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Naval Officers Club 12 Manager 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be fits Department of Health and Mental Hy Important: If Item 27 is marked oth eny liuly or other traumatic event ang. 17. Father's Name (First, Middle, Last) Be Elizabeth Rochild Alfred Kyle ္ဌ 19a. Informant's Name/Relationship (Type, Print) Gran-19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Yolandreia Butler / daughter 12505 Bredon Ct., Brandywine, Maryland 20613 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition tX Burial 2 ☐ Cremation 3 X Removal from State 4 □ Donation 5 □ Other (Specify) Barrancas Nat'l Ceme. 03/17/2006 | Pensacola, Florida 21. Signature of Funeral Service Licensee 22. Name and Address of Facility The Derrick C. Jones F/H, P.A. 4611 Park Hgts. Ave., Baltimore, Maryland 21215 s ed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ch ine. Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that shock, or heart failure. List only one cause on Immediate Cause (Finat disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially tist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of): Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No certificate 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) 1 ☐ Yes 2 ▼ No Other: 4 Nursing Home 5 Residence 6 Dether (Specify) NO SPICE ို 1 Inpatient 2 ER/Outpatient 3□ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification; 1 DNatural 5 Pending investigation 1 ☐ Yes 2 ☐ No death 2 Accident Director: 6 Could not be determined 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Thomscide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signay re and title of certifier 29d. Date signed (Month, Dav. Year) 12907 Name and address of person who completed cause of death (Item 23a) (Type, Print) NEUTAN NISHNAN 31. Date filed (Month, Day, Year) 32. Pegistrar's Signature State MAR 1 3 2006 Registrar

		State of Maryland / Department of Health and M	•	-	-5 -20 FM - FM - / S
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Funeral Director		5. Social Security Number 6. Sex 1 Months Days Hours Min.	8. Date of Birth (Month, Day, FEB . 23	Year) Cour	place (State or Foreign htry) AROLINA
D.		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location	FED, ZJ		Od. Inside City Limits
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10		29c. License number  D 3 (Tub)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  U 11 in T Tanno M II vi Livingston Rand, Food  31. Date filed (Month, Day, Year)  MAR 1 3 2006	WACH	ingly in a	ylmd
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*	Funeral Director		216-34-0739	1-1 M 2□F	_	Months		Hours	Min.	8. Date of Bin (Month, Da 6/2/19	7. <i>Year)</i> 36	MAI	inthplace (State or Foreign Country) RYLAND
	and *		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town	or Location			<u> </u>				10d. Inside City Limits
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g	otho	ВеС	17. Father's Name (First, Middle,	Last)				18. Mothe	r's Name	(First, Middle,	Maiden S	Su <i>ma</i> m <i>e)</i>	<u> </u>
Maryland	Menta Menta arked arked	To E	DOMINIC G. KRE	ECZMER						BORKOW			· · · · · · · · · · · · · · · · · · ·
Z Z	12 sh h and 7 le m treum		19a. Informant's Name/Relations			Mailing Address				WSON,		Town, State, 2 <b>12</b> 86	Zip Code)
	s 1 and f Healt Item 2 other		DOROTHY A. KRE 20a. Method of Disposition	ECZMER/ WIFE		529 DRUI Disposition (Na		ROAL		ate			or Town, Slate
Baltimore,	00==		1 ⊠Burial 2 ☐ Cremation		l cometon	, crematory or o	other plac	(e)	3/13	3/2006			
≣			4 ☐ Donation 5 ☐ Other (S		OAN LAV			es of Facilit					HOME, P.A.
Ba	permit. Departr Import		I Signature in runnian segrica	V. Hack						D. TOW			1286
	^ *		23a. Parky. Enter the disease, o	r compligations that cause	d the death. Do no								Approximate
L			23a. Party. Enter the disease, o shock, or heart failure. List transdiate Cause (Final	only one cause on each li	ine.		_			, ,			Interval Between Onset and Death
100	Physician /Medical		disease or condition resulting in death)		en car		DEH7	7/-					
	Examiner			CORON	a consequence of	): 27 <del>28</del> 4	2150	4-					CNKNAM
6	, W. y	Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	U	a consequence of		DISE	m>E					<u></u>
X	be executed sicien and burial-transit	Examin	Cause (Disease or injury that initiated events	<b>S</b> c					_				
760,7	e exe ien ar urial-t	Ex	resulting in death) Last	Due to (or as	a consequence of	f):							
	9 % 6	licai		d									
68	death certifica e attending ph d for use as th	Mec	IF FEMALE:										
Вох	ath ce ttend or us	an/	23b. Was decedent pregnant in the past 12 months?		2 Fetal death	3 □Ectopic p					23	3d. Date of d Month	elivery Day Year
0	at the dea by the a tached fo	Physician/Med	1 Yes 2 No	4□Pregnant a 9□ Unknown	t time of death	5 🗌 Other (s	pecify)						Duy tou.
ď.	het thid by		Part II. Dther significant conditi	ons contributing to death it	out not resulting in	the underlying	Carred William	en in Part I		23e Did t	nbacco us	e contribute	to the cause of death?
Š,	The law requires thet the site has been signed by the bage 2 should be detached.	þ	Tarri, other organicant canali	one contributing to again t	out the to saiding in	and underrying t	sauso givi	off in a ditt	•	1	_		Probably 4 □Unknown
0	w require been si should I	etec											
Records,	: The law cate has t , page 2 s	Completed								24a. Was		24b. Were prior to death?	autopsy findings available completion of cause of
<u> </u>										1 ☐ Yes	2 No	1 🗆 Ye	
Vital	ilcian: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:			Oth	00		(Check only o			
5	Phys this al dir	2	1 ☐ Yes 2 No  27. Manner of Death	1 ☐ Inpati			JA	4 🗆 140		me 5 Resi			pecify)
ב	ding Ph h. After thi funeral	lo	1 Natural 5 ☐ Pendi	ng (Month, Da	y Year) In	jury	28c. Injun Worl	k? Yes 2□		200. Describe	iow injury	occurred	
S	ttend death stor:	icat	3 Suicide 6 Could		jury - At home, far			163 2		28f Location (	Street and	Number or	Rural Route Number,
Division of	after Direct	Certification:	4 Homicide determ	building, e	tc. (Specify)	m, street, ractor	y, onice			City or To		74011207 07	Tarai Fibale Fallibor,
	ne Hospitel or Attendin n 24 hours after death. ne Funerel Director: A pletaly filled in by the fu		29a. Certifier 12 Certifyi	ng Physician: To the best	of my knowledge,	death occurred	at the tin	ne, date an	d place, a	and due to the	cause(s)	and manner	as stated.
	To the Hospitel or Attending Physicien: within 24 hours after deals. To the Funerel Director: After this certific completely filled in by the funeral director,	Medical	one)	Examiner: On the basis of and manner st	ated.				ith occurr	ed at the time,			
	Viit To Con	2	29b. Signature and title of Sertific			1		e number				-	nth, Day, Year)
•			-/4/	(ND X	<b>シ</b>		031	187			14N	ZCH 10	, 2006
	10		30. Name and address of person	who completed cause of a	death (Item 23a) (1	Type, Print)	WORD	c R	6	Roman		7104CA	), 2006 N)
33 )	Sta	te	31. Date filed (Month, Day, Year		rar's Signature	Some Some	و د د		1	2-141-4	, ,	الدا ملاه	<i>y</i>
	Registr		MAR	1-3 2006	aliens for	6004							

ADH LAWRENCE L. KUYAWN 06-1487

Maryland 21215-0036

Baltimore,

P.O. Box 68760,

Division of Vital Records,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Unpend item#23a, 27, pen/E, CS33, 3/15/06 TT State of Maryland / Department of Health and Mental Hygiene 07536 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) FEBRUARY 28, 20006 **Physician** 1115 Ам Lawrence L. Kuyawa /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 206 WEST 11TH AVENUE **BROOKLYN** ANNE ARUNDEL | If Under 1 Year | ff Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | (Month, Day, Year) | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1⊠M 2□F Yrs Director 219-40-3374 63 Feb 24, 1943 Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location permit. Pages 1 end 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: if item 27 is marked other then "naturel", or iteme 23a or 28a-f show with injury or other traumatic event, the Maulcal Examiltant rount to another contribut at once. 10a. State 10b. County 10d. Inside City Limits 1 ☐ Yes 2√2 No Anne Arundel Brooklyn Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 206 W. 11th Avenue Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Bfack, White, etc. 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: white Completed by 3 Widowed 4 Divorced 60-63 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Efementary/Secondary (0-12) Coffege (1-4or 5+) 12 warehouseman auto parts 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Be Lawrence Louis Kuyawa Sr Ruth Lanore Wengert 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donna Harris/sisiter 6 Oak Road Selbyville, DE 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☑ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street
Baltimore, MD 21201 21. Signature of Euneral Servic Licensee
Ronal IIS. Wade, Director 1000 cor Baltimore, MD Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each fine. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** a Atherosclerotic cardiovascular disease /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leaving to infilinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner physician and s the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical for use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetaf death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) ate hes been signed by the page 2 should be deteched 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 2 X/10 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

Yes 2 No autopsy performed? 1X Yes 2□ No director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 □ No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this After this funeral of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 XNatural 5 Pending Infury 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the ft. death. investigation 2 Accident 3 Suicide 6 Could not be 28e. Pface of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

What call Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) OCME MARCH 1, 2006 30. Name and address of person who complet ed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

MAR 1 3 2006

32 Registrar's Signature

111 PENN STREET, BALTIMORE, MARYLAND, 21201

			For State Registrar	State o	f Marylan	-	artment				lental Hyg	giene	06	07538
			Decedent's Name (First, Middle,	Last)							2. Date of Dea	ith		3. Time of Death
	Physici /Medic		Hele:	n Beatric	e LaBor	ı					Month March	7 <b>,</b>	2006	11:35 A <sup>M</sup>
	Examin		4a. Facility Name (If not institution,	give street and nur	mber)		4b. City,	Town, or	Location of	of Death		4c. Co	unty of Deati	n
			Shady Grove Adv					ckvi					ntgom	
	Funeral		,	5. Sex 1 ☐ M 2 🖾 F	7. Age (In yrs.	last birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Birtl (Month, Day	h /, Year)	9. Birti Co	nplace (State or Foreign untry)
	Director		303-14-0586 Usual Residence of Decedent		91	115.					Oct. 8,	1914	In	diana
	/land		10a. State 10b. County		10c. Cit	ty, Town or Lo	ocation							10d. Inside City Limits
	Mary	ţo	Maryland Montgo	mery	Mo	ntgome	ry Vi	11ag	e					1 ☐ Yes 2 🕅 No
	th the	lrec	10e. Street and Number				10f. Zip	Code				10g. Citizer	of What Co	untry?
	23a	a	9931 Ridgeline	Drive			2	2088	6			Un	ited S	States
	tams	Funeral Directo	11. Marital Status	Armed Fo		.S. 13.	Was Deced If Yes, spec	ent of Hi ify Cuba	spanic Ori n, Mexicar	igin? (Spo n, Puerto	ecify Yes or No- Rican, etc.)	14.	Race - Ame Black, White	
36	rs afte	by F	1 ☐ Never Married 2 ☐ Marrie 3 🕅 Widowed 4 ☐ Divorced	d 1 □ Yes If Yes, Giv Year or D	/8		1 ☐ Yes 2	No 🖾	Specify:			Sp	ecify: W	hite
21215-0036	within 72 hours after death with the Maryland ene then "naturel", or items 23e or 28e-f ehow fa Madical Exeminer must be notified at	ed	15. Decedent's	Education	4103.	16a. Dece	dent's Usua	l Occupa	ation			16b. Kind	of Business/I	Industry
215	hin 72	ple	(Specify only highest Elementary/Secondary (0-12)	grade completed) College (1	1-40r 5+)	(Give	kind of wor DO NOT us	k done d e retired,	luring mos )	it of work	ing			•
2	ge wit	Completed	12	3333			Audit	C1e	erk				Union	
D D	should be filed within 72 hours after death with the Marylan ind Menial Hygiene a marked other then "natural", or items 23a or 28a-1 ahow imatic avent, its Medical Examinat must be notified at	Be	17. Father's Name (First, Middle, L	-							(First, Middle,	Maiden Su	mame)	
<u> </u>	should be and Mental marked o	၉	Watts Bond Brat								Furnish			
Maryland	es 1 and 2 should b of Health and Menti f Item 27 is marked r other treumatic a		19a. Informant's Name/Relationshi				-				al Route Numbe	-		
45	1 and Health em 2 ther	1	Nancy A. Lieb /	Daugnter	20b. F	Place of Dispo	sition (Nam	e of	1		Gaither		Mary.	Land 20878
ဋ	ages int of t: If It		1 X Burial 2 Cremation		State G	ate of	Heav	her place en	<sup>9)</sup>   1		13,			ing, Marylan
altimore,	permit. Pages 1 Department of H Important: If Ite any njury or ott		4 □ Donation 5 □ Other (Sp. 21. Signature of Funeral Service L			Cemet		d Addres	s of Facili	20				
ñ	Deg Gm gn gn gn gn gn gn gn gn gn gn gn gn gn		► MAHAA (XI)	MUX	MO1	1420 RC	bert A O West	. Pun Mont	mphrey	Fune v Ave	ral Home/	Rockvi ville.	lle, In Marvia	nd 20850-2805
			23a. Part1. Enter the disease, or o shock, or heart failure. List o	complications that controls on a	aused the deat		and the same of th	Caracher School Spirite						Approximate Interval Between
	Physician	a 1	Immediate Cause (Final disease or condition	_a Seps										Onset and Death  2 Days
	/Medical		resulting in death)		or as a conseq	juence of):								z Days
н	Examiner		Sequentially list conditions.		monia									1 Day
	be slt	lner	Sequentially list conditions, any, leading to min adiabacause. Enter Underlying Cause (Disease or injury		(or as a consec									
	end end I-tran	Examin	that initiated events resulting in death) Last	V	estive (or as a conseq		Failu	re					-	l Day
760,	death certificate be executed e ettending physician end ad for use as the burial-transit	cal E			esis	,,								2 Davs
89	ificate g phy as the			0.										2 24/6
Box	leath certificate the strain of the second o	M/	IF FEMALE: 23b. Was decedent pregnant		come of pregna		Ectopic pre					23d	. Date of deli	very
	ed for	sicie	in the past 12 months? 1 ☐ Yes 2 🖾 No		ant at time of d		Other (spe						Month	Day Year
<u>ч</u>	at the ded by the e	Physician/Med	9 Unknown								T 00 Billion			
ŝ	law requires that the es been signed by th 2 should be detache	Ď	Part II. Other significant condition Cerebral Vascul			sulting in the u	nderlying ca	luse give	en in Part I			obaccouse ′es 2⊡N		the cause of death?
Š	w require been si should I	Completed		ar necru	CHUB		- "					-		
Ä	The law ste hes page 2 :	E E									24a. Was autop perfor		prior to death?	topsy findings available completion of cause of
ē		ပိ	25. Was case referred to medical						oc Dise	ad Doot	1 ☐ Yes	2 No	1 🗆 Yes	2 □ No
5	Physician: this certific ral director,	To B	examiner?	Hospital: 1X	npatient 2	ER/Outpatie	nt 3 DO	A Othe			me 5 ☐ Resid		Other (Sner	ntv1
0			27. Manner of Death	28a. Date	of Injury th, Day Year)	28b. Time o		Bc, Injury Work	at		28d. Oescribe h			
<u> </u>	Attending ir death. actor: After by the fune	atic	1 ⚠Natural 5 ☐ Pending 2 ☐ Accident investigs	ition	,,	,,	М		res 2	No				
Division of Vital Records,	of or Attance efter death Diractor:	Certification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	289. Place	of Injury - At hing, etc. (Specil	ome, farm, st fy)	reet, factory,	office			28f. Location (S City or Tow		lumber or Ru	ral Route Number,
	Hospitel of hours er Funeral D		200 Contilion (X) Contituing	Dhusisian To the	h									
	5 4 1 5 6 5 4 1 5 6	Medical	29a. Certifier 1 △ Certifying (Check only 2 ☐ Medical E	Physician: To the xaminer: On the band man	asis of examination of the state of the stat	tion and/or in	n occurred a vestigation,	in my op	e, date an pinion, dea	id place, ath occurr	and due to the o	date and pla	d manner as ace, and due	stated. to the cause(s)
	To the within 2 To the complete	Me	29b. Signature and title of certifier	1		~	29c.	License	number			29d. Date s	igned (Monti	n, Day, Year)
	1d		Althur	asid	M.	$\mathfrak{D}$ .		D5.	5054			Mar	ch 7,	2006
	151		30. Name and address of person w	no completed caus	se of death (Iter	n 23a) (Type.	Print)						-	
	10		Attan Kasid, M				d, Ro	ckvi	11e,	Mary	yland 2	20855		
	Sta		31. Date filed (Month, Day, Year)	III.	egistrar's Signa									
	Registr	ar	MAR 1 3	2006	ROBEL A	7 60	3454							

DHMH 17 Rev 1/2001

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			For State	State of Ma						nd Men		20	nne	07500	)
	Physici	22	State RegistrarAmend item  1. Decedent's Name (First, Middle, La	st)	_	38535	J1419410 <del>1</del>	OUN	eaur		Date of Dea		Year	3. Time of Death	2
10 Co (dec	/Medic	al	4a. Facility Name (If not institution, give	LE WIS	>		4b. City_I	own, or Lo	ocation of		bival	4	unty of Death	10.00 P	М
20			5. Social Security Number 6. S	ical ()	Utc.	ast birthday)	If Under 1	Year II	1 'nu	1 ne	Date of Birth		9 Birthi	place (State or Foreig	ian
	Funeral Director		218-60-9798			84 Yrs.	Months	Days	Hours	Min.   (	Month, Day $1$ ,	(, Year)	Cou	unk unk	
	tryland thow		Usual Residence of Decedent  10a, State 10b, County		O.	, Town or Lo				. /				10d. Inside City Limit	
	the Marine	recto	10e. Street and Number	2	150	2L41	10f. Zip C		Ci	44		10g. Citizen	of What Cou	1 Yes 2 N	
	s 23a or	Funeral Director	1019 E 1.	estin :	54	2 42		202	en Calab	-2 (04	V N-	45	) Race - Ameri	an tadian	
36	72 hours after death with the Maryland naturel', or Items 23a or 28a-f ehow dicat Eastol at must be notified at	by Fune	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1  Yes 2 N If Yes, Give Year or Dates:			Was Decede If Yes, specif 1 ☐ Yes 2		anic Origii Mexican, S <i>pecify:</i>	Puerto Rica	n, etc.)	Į.	Black, White,		
21215-0036	d within 72 hours after death with the Marylan plene. I then "naturel", or Items 23a or 28a-1 show The Madical Exactinat transit to notified at	Completed	15. Decedent's Elementary/Secondary (0-12)	ade completed)  College (1-4or 5	+)	(Give	dent's Usual kind of work DO NOT use	done duri		of working	unk	16b. Kind	of Business/Ir	dustry unl	K
Maryland 2	be filed tal Hyg d othe event,	To Be Co	unk  17. Father's Name (First, Middle, Lass  UN KNOW					18		's Name (Fir			name)		
Mary	12 sho h and 7 is mu ireum		19a. Informant's Name/Relationship				ng Address (						wn, State, Zij	Code)	1
Baltimore, I	other	To the second	Mercy Medical Cer  20a. Method of Disposition  1 □ Burial 2 □ Cremation 3 □  4 □ Donation 5 ☒ Other (Species)	Removal from State_	20b. Pi	lace of Dispo	sition (Name	9 of	ace .	Date	nore,		on - City or T	own, State	
Balti	permit. Page Department of Important: if any injury or		21. Signature of Fuperal Service Lea		ctor		Name and State A Baltimo			aord 21201	655 W	. Balt	imore	Street	
	Physician		23a. Part1. Enter the disease, or conshock, or heart failure. List only tamediate Cadse (Final disease or condition resulting in death)	one cause on each lin	Θ.	ual	er the mode	of dying, s	such as ca	ardiac or res	spiratory ar	rest,		Approximate Interval Between Onset and Death	
25.	/Medical Examiner			Due to (or as a	1	ience of): LULL	lla	ato	anti	alis	pue	nuo	uin	lldays	
30,	death certificate be executed e ettending physicien and id for use as the burial-transit	i Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a	ma	M.	arfe	ny	de	seas	R			rsyrs	
68760	ificate be er g physicien as the buria	edical		d											
O. Box		Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. tf yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 🗌 Fetal	death 3[	Ectopic pred Other (spec			<del></del>		23d	Date of deliv Month	ery Day Year	
σ.	ires tha signed d be de	ρ	Part II. Dther significent conditions	contributing to death bu	ıt not resu	ulting in the u	nderlying cau	use given	in Part I.		23e. Did to	-		he cause of death? pably 4 □Unknow	VΠ
of Vital Records,	The ete h page	Completed									24a. Was autop perfor 1 ☐ Yes	sy	4b. Were auto prior to co death? 1  Yes	opsy findings availab mpletion of cause of 2□ No	ole f
Vita	Physician: this certifice ral director, p	o Be	25. Was case referred to medicat examiner? 1 ☐ Yes 2 ☐ No	Hospital: Inpatie	nt 2 🗆 I	ER/Outpatier	nt 3 DOA	Other		of Death <i>(Cf</i> sing Home			Other (Speci	(v)	
Division o	ath. r: After se fune	Certification: T	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation		Y Year)	28b. Time o tnjury	f 28	c. Injury at Work? 1  Ye		28d.		ow injury oc			
Divis	tel or Atten rs after deat al Director: ed in by the	Certific	3 Suicide 6 Could not l				reet, factory,	office			Location (S City or Tow		umber or Rur	al Route Number,	
	To the Hospitel or Atter within 24 hours after de To the Funeral Directo completely filled in by th	edical	(Check only /2   Modical Evo	hysician: To the best of miner: On the basis of and manner sta	avamina!	tion and/or in	actionation :	a mu anin	ion donth	a cooursed a	t the time .	data and ala	an and due t	a the severalel	
	with To com	Σ	29b. Signature and title of certifier  30. Name and address of person with the company of the certifier of t	4110	Atte	udu	29c.	DS6	399			Ebw	gned (Month,	S, 2006	
			30. Name and address of person who	completed cause of d	eath (Item	23a) (Type,	edic	al (	ent	ar 3	8 10	r. Pac	187.	Balhner	20
	Sta Registi		31. Date filed (Month, Day, Year)  MAR 1 3 20	. Registra	ar's Signa	Ture Soc	affe d								

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Neme (First, Middle, Last) Day **Physician** February 23, 2006 6:56 AM Etta R. Lyles /Medical 4c. County of Deeth 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** 1706 Earl Drive Bel Air Harford 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) 6. Sex 5. Social Security Number **Funeral** 1 ☐ M 2 🂢 F Nov 9, North Carolina 76 Director 246-38-8184 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County or then "natural", or items 23s or 28s-f show the Madical Example: country country for natified at 1 ☐ Yes 2√ No Director Bel Air MD Harford 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21015 USA 1706 Earl Drive Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ ₹ No If Yes, Give \* Year or Dates: 11. Marital Status within 72 hours after 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: white ۵ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry fited within Hygiene. other then " College (1-4or 5+) Elementary/Secondary (0-12) education librarian permit. Pages 1 and 2 should be filed 1 Department of Health and Mental Hygis Important: If item 27 is marked other 1 any injury or other traumatic event. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Etta Mae Honeycutt James Mozelle Reid 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1706 Earl Drive Bel Air, MD 21015 Charles A. Lyles/son Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 X Donation 5 ☐ Other (Specify) 21. Signature of Funeral S who Licensee Romand S, Wade Director State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 men 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Box 68760, Physician/Medical as the IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death use 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy Day Month for 5 Other (specify) P.0. been signed by the should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Records, 3 ☐ Probably 4 ☐ Unknown 2 No 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has b lirector, page 2 sl autopsy performed? Yes 22 No 2 No 1 Yes 1 ☐ Yes Division of Vital Hospital or Attending Physician: 26. Place of Death (Check only one) director, 25. Was case referred to medical examiner? Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 24 hours after death.

Funeral Diractor: After thiletely filled in by the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) 3 🖺 Suicide 4 | Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical within 2 To the the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier ٥ 6 Blvd Battemore, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Security onathan 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 2006 Registrar

			for State Registrar	State of Ma	aryland	-	artment rtificate			and M		jiene)	16	07541
28	Physici	an	1. Decedent's Name (First, Middle, L								2. Date of Dea Month	Day.	Year	3. Time of Death
45	Physici /Medic		ESTHER								MARCH		2006	
46	Examin	er	4a. Facility Name (If not institution, g				,		Location o				nty of Death	
,			Genesis Brightw  5. Social Security Number 6.		e (In yrs. las	t birthday)	If Under		If Under		8. Date of Birth	)		place (State or Foreign intry)
	Funeral Director		212-18-2317	1□M 2▼F	95	Yrs.	Months	Days	Hours	Min.	Oct 10,	, Year)	Mary	
i.			Usual Residence of Decedent											
	ehow	_	10a. State 10b. County		10c. City, 1									10d. Inside City Limits 11√2 Yes 2 ☐ No
	8a-f	Director	MD		Ва	ltimo		0.1.			T .	10= 0:1:		
	with ti		10e. Street and Number				10f. Zip					10g. Citizen o	or what Col	intry r
	ns 23	Funeral	4501 W. Forest I	2 Avenue	Ever in U.S.	13.	Was Deced	ent of Hi	1207 Ispanic Ori	gin? (Spe	ecify Yes or No-	US.	A ace - Amer	ican Indian,
m	r Hen	표	t Never Married 2 Married	Armed Forces?			If Yes, spec	ify Cuba	n, Mexicar	n, Puerto	Rican, etc.)		lack, White	
<u>8</u>	rali, o	l by	3   Widowed 4 □ Divorced	If Yes, Give Year or Dates:			1□Yes 2	2XI No	Specify:			Spec	b.	lack
5-0	within 72 hours after death with the Maryland ene. than "netural", or tems 23e or 28e-f ehow the Madigal Exterible could be indiffied at	Completed	15. Decedent's (Specify only highest of	Education grade completed)		(Give	denl's Usua kind of wor	k done o	during mos	t of worki	ing	16b. Kind of	Business/I	ndustry
2	within ane. than	du	Elementary/Secondary (0-12)	College (1-4or 5	5+)		DO NOT us		,			Doord	ae ma	
р 2	Hygie Hygie Sther ent,		17. Father's Name (First, Middle, La				ecret	ary	18. Mothe	er's Name	(First, Middle,			lucation
Maryland 21215-0036	id be ental ked o	To Be	Samuel Arthur	Short					Eva	Bert	ina Sco	tt		
ary	shou and M B far umat	-	19a. Informant's Name/Relationship	(Type, Print)		19b. Maili	ng Address	(Street a	and Numbe	er or Rura	al Route Numbe	r, City or Tow	vn, State, Z	ip Code)
Σ	and 2 alth on 27 i		William Lottier	Jr/son					t Par		enue Ba			
ore	of He of He or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3	☐Removal from State			osition (Nam matory or of		e)		Date	20c. Location	n - City or I	fown, State
Ē	Pag tment tant:		4 ☑ Donation 5 ☐ Other (Spec	cify)					ļ					
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: if Itam 27 is flarked other than "natural; or Items 23e or 28e-1 ehow amportant: if Itam 27 is flarked other than "natural; or Items 23e or 28e-1 ehow amy injury or other traumatic event, the Mardical Extending from the notified at any injury or other traumatic event, the Mardical Extending from the notified at		21. Signature of the raise of Lie nonal of S.	Wade Wir	ector	1.0	2 Name and State Baltin		_		d 655 W	. Balt	imore	Street
			23a. Part1. Enter the disease, or co shock, or heart failure. List on	implications that caused by one cause on each li	d the death.	Do not en	ter the mode	e of dyin	g, such as	cardiac o	or respiratory ar	rest,		Approximate Interval Between
4	Physician		Immediate Cause (Final disease or condition	ADVI	ANCE	D	DE	ME	17 VE	A				onset and Death
	/Medical Examiner		resulting in death)	Due to (or as	•			01-0	2					
₹.		-	Sequentially list conditions, if any, leading to immediate	b. FAIL  Due to (or as			0 7	NK	LIVE					DAYS
	nsit	II.	cause. Enter Underlying Cause (Disease or injury		, , , , , , , , , , , , , , , , , , , ,									
Ć	te be executed ysician and he burial-transit	Examiner	that initiated events resulting in death) Last	c Due to (or as	a conseque	nce of):								
Box 68760,		cai		d								-4.		
89		Physician/Med	IF FEMALE:											
BO.	ath ce	lan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome	2 Fetal de	eath 3[	□Ectopic pr						Date of deli Month	very Day Year
P.O.	The law requires that the death certific ate has been signed by the attending page 2 should be detached for use as	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Pregnant a 9 ☐ Unknown	t time of deal	tn 5L	Other (sp	еспу)						
	Physician: The law requires that the this certificate has been signed by the rail director, page 2 should be delached.	y Ph	Part II. Other significant conditions	s contributing to death b	out not resulti	ing in the ι	ınderlying c	ause givi	en in Part I	l.	23e. Did to	bacco use co	onIribute lo	the cause of death?
rds	quires n sigr uld be	ed by						<del></del>			1 🗆 Y	′es 2□No	3 🗆 Pro	bably 4 Unknown
00	s bee	Completed									24a. Was autop		b. Were au	topsy findings available completion of cause of
Ä	The I	E									perfor	med? 2U No	death?	
/ita	ilcian: Th certificate rector, pag	Be (	25. Was case referred to medical examiner?							e of Deat	h (Check only o	ne)		
<u>}</u>	Physic this c	ဥ	1 Yes 2 No		ent 2 EF				4 ANI		me 5 Resid			eify)
no	ding P	tlon	27. Manner of Death  Natural 5 Pending investigat	28a. Date of Inju (Month, Da		8b. Time o Injury	M	8c. Injun Worl	ya≀ k? Yes 2 🗆		28d. Describe h	low injury occ	urreu	
Division of Vital Records,	Attanding or death.	flca	3 Suicide 6 Could no	t be 28e. Place of In	jury - At hom	e, farm, st							mber or Ru	ral Route Number,
á	rs after al Dire	Certification:	4 Homicide	building, e	tc. (Specify)						City or Tou	m, State)		
	To the Hospital or Attanding Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	edicai		Physician: To the best caminer: On the basis of and manner st	4						4			
	To the To the comple	ĕ	29b. Signature and title of certifier				290	. Licens	e number			29d. Date sig	ned (Monti	n, Day, Year)
)			spr	MD			1	000	5313	50		MARCI	H 60	n 2006
			30. Name and address of person who	no completed cause of	death (Item 2	3a) (Type	Print)	190	50	no4	10,501	MEIL	ORID	HP 7104(-
		ate	29b. Signature and title of certifler  30. Name and address of person where the second	32 Regisli	rar's Signatur	гө	ودهد				, (	, 0 00,1	. 3114	21-13
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Thomas murphy

			For	y <b>pe or Prin</b> State of Ma						•		_	07542
			1 - State Registrar			Cei	tificate	of D	eath		Reg. No.		
	Physicia	an	1. Decedent's Name (First, Middle, Last)							2. Date of Dea	Day	Year	3. Time of Death
I	/Medic	al	Thomas J. Murphy,  4a. Facility Name (If not institution, give s				4h City 1	Town or I	ocation of Deat	MARCH	7	OO 6 ounty of Death	0815 A M
E	Examin	er	BALTIMORE WASHING		CAL CE	NTEL			LIENIE	"			Zumi> EL
	Funeral		5. Social Security Number 6. Sex	7. Age	(In yrs. last b		If Under Months		If Under 24 Hrs Hours Min.				place (State or Foreign
	Director		220-14-3720	M 2□F	81	Yrs.	Wichting	Days	Tiours	117197	1924	Mary	yland
	land w		Usual Residence of Decedent  10a. State 10b. County		10c. City, To	wn or Lo	cation						10d. Inside City Limits
	Mary -f sh	tor	Maryalnd n/a		Bal	timo	re						1 XYes 2 □ No
	death with the Maryland ime 23s or 28e-f show it must be notified at	Director	10e. Street and Number			_	10f. Zip	Code			10g. Citize	n of What Cou	ntry?
	ath w		1609 Inverness Ave					230			USA		
	ler de Iteme	Funeral	11. Marital Status 1 Never Married 2 Married	<ol> <li>Was Decedent E Armed Forces?</li> </ol>		13. \	Was Deced f Yes, spec	ent of His ify Cuban	panic Origin? (S , Mexican, Puer	Specify Yes or No- to Rican, etc.)	- 14	. Race - Ameri Black, White	
920	hours after tural', or Ite	þ	3 X Widowed 4 □ Divorced	1 ☑ Yes 2 ☐ N If Yes, Giv <i>e</i> Year or Dates:	10		1 ☐ Yes 2	X No	Specify:		S	pecify: V	White
9500-5121	be filed within 72 hours after death with the Marylan tal Hygiene. Id other than "natural", or Iteme 23a or 28e-f show event, the Medical Evantiner must be notified at	Completed	15. Decedent's Educ (Specify only highest grade	ation completed)	16	a. Dece	dent's Usua kind of wor	l Occupat	tion uring most of wo	rkina	16b. Kind	of Business/Ir	ndustry
121	within 72 ene. than "na	mpl	Elementary/Secondary (0-12)	College (1-4or 5		life. I	DO NOT us	e retired)			Dani	n+ Ch	
70	a filed v other t vent, th	e Co	17. Father's Name (First, Middle, Last)	0		Prin	icer_		18. Mother's Na	me (First, Middle,		nt Shor umame)	)
land	lid be lental ked o	To B	Luke Murphy						Mildre	d (unk)			
Mary	2 should be and Mental Is marked sumatic ev		19a. Informant's Name/Relationship (Typ	e, Print)	19	9b. Mailir	ng Address	(Street as	nd Number or R	ural Route Numbe	er, City or 7	Town, State, Zi	o Code)
Σ α`	and 2 lealth m 27 her tra			Son						, Baltim			
5	uges 1 nt of H : If ite or ot		20a. Method of Disposition 1 ☐ Burial 2 🌠 Cremation 3 ☐ Re	emoval from State	20b. Place cemen					Date		ation - City or T	
gaitimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 Is marked any injury or other traumatic evonce.		<ul> <li>4 □ Donation 5 □ Other (Specify)</li> <li>21. Signature of Funeral Service License</li> </ul>	•	Bayvi			-4		3/2006 ubbard Fi			Maryland
n D	Department of the partment of		X. DLC	D: 2									ind 21229
F	1000		23a. Part1. Enter the disease, or complice shock, or heart failure. List only on	ations that caused	the death. De								Approximate Interval Between
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	/Medical Examiner		resulting in death)	Due to (or as									
	LAGITITICI	<u></u>	Sequentially list conditions, b	Due to (or as a	consequenc	e of):							
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Ď.	te be executed ysicien and e burial-transit		that initiated events c. resulting in death) Last	Due to (or as a	consequenc	e of):							-
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XOD	eath c attend for us	cian	in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant at	2 🗌 Fetal dea		Ectopic pre				23	<ul> <li>d. Date of deliv</li> <li>Month</li> </ul>	ery Day Year
j.	t the d by the ached	hysk	1 Yes 2 No 9 Unknown	9□ Unknown			3 0 ( )						
r.	requires that the een signed by th hould be detache	by P	Part II. Other significant conditions con	tributing to death bu	ut not resulting	; in the u	nderlying ca	ause giver	n in Part I.	23e. Did to	obacco use	contribute to	the cause of death?
cords,	equire sen si could I									1 🗆 \	/es 2□	No 3 ☐ Pro	bably 4 @Unknown
Ū	a taw r has be	Completed								24a. Was autop	sy	prior to co	opsy findings available ompletion of cause of
T o	n: The icate h									1 ☐ Yes		death? 1 ☐ Yes	2 □ No
VII	Physicien: The this certificate har all director, page	o Be	25. Was case referred to medical examiner?  1 Yes 2 No	ospital: 1 Inpatie	nt 2□ER/0	Outnation	nt 3□ DO	Othor		ath <i>(Check only o</i> Home 5 ☐ Resid		Other (Speci	6.1
0	g Phy er this	<b>—</b>	27. Manner of Death	28a. Date of Injur (Month, Day		. Time of		Bc. Injury Work		28d. Describe h			197
300	endin sath. or: Aft he fur	atlo	1 Natural 5 Pending 2 Accident investigation	(100181, Da)	7047)	ициту	М		es 2 □No				
DIVISION	or Att fter de Directi in by t	Certification;	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Inju- building, etc	ıry - At home, :. (Specify)	farm, str	eet, factory	, office		28f. Location (S City or Tox	Street and I vn, State)	Number or Rur	al Route Number,
	pitel		29a. Certifier 1 Certifying Phys	ician: To the hest o	of my knowled	ne death	n occurred :	at the time	a date and place	and due to the	221120/2) 21	ad mannet as	rtated
	To the Hospitel or Attending Physicien: within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director,	edical	(Check only 2 Medical Examin	er: On the basis of and manner sta	examination a	and/or in	vestigation,	in my opi	nion, death occi	urred at the time,	date and p	lace, and due t	to the cause(s)
	To th withir To th comp	Me	29b. Signature and tyle of certifier		-		290	. License				signed (Month,	
			1 100	TO	COM		2	745	, १८५६	Burnie	YLayc	W 11.	2066
	211		30. Name and widress of person who con	moleted cause of de	SO174	(Type	Print)	. (	· Crons	Burner	M	1) 2	O Car
	Sta	te	31. Date filed (Month, Pay, Year)										
	Registr		MAR 1-3 200		J. St.	400	ulis						
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			Amend item#20a-c,perlH	ype or Print in Bla ,9853,3/13/06 TT State of Maryland	ack Ind / Depa	delible Ink. Irtment of H	Ensure /	<b>All Copies</b> Mental Hy	Are giene	Legible.	n
			1 - For State Registrar		Cer	tificate of	Death		Reg. No	UUU.	0/040
T de	Dhysiai	2 p	1. Decedent's Name (First, Middle, Last)					2. Date of De Month	aath Da	y Year,	3. Time of Death 3:53AM
	Physicia /Medic		Jeanette	D.			Mack	FEB	27	2006	
	Examin	er	4a. Facility Name (If not institution, give s SINAL HOSPITAL OF 5. Social Security Number 6. Sex	BATIMORE	t hirthdau)		RE CITY  If Under 24 Hrs			. County of Death	
	Funeral Director			M X□F 80	Yrs.	Months Days	Hours Min	. (Month, D	ay, Year) <b>01</b>	25	place (State or Foreign intry)
	yland sow		10a. State 10b. County	10c. City, 1	Town or Loc	cation					10d. Inside City Limits
	a-f sl	ctor	MD NA	Bal	ltimo	ore					1X Yes 2 □ No
	death with the Maryland rns 23a or 28a-f show Fridet by ridding at	Director	10e. Street and Number			10f. Zip Code			10g. Cit	tizen of What Col	intry?
	s 23s		3803 Bonner Roa	ad Apt 2  2. Was Decedent Ever in U.S.	12.4	212		Specific Ven or N	•	U . S . A .	ione todino
۵		Funeral	11. Marital Status 1 Never Married 2 Marned	Armed Forces?  1 Yes 2 No If Yes, Give	1	Vas Decedent of H Yes, specify Cuba ☐ Yes 2 XNo		to Rican, etc.)	0.	Black, White	, etc.
0000	hours after tural', or ite	d by	3X Widowed 4 □ Divorced	Year or Dates:		LITES ZLZDNO	<i>Specily</i> :			Specify: B	lack
ה	"natu	iete	15. Decedent's Educ (Specify only highest grade		(Give	ent's Usual Occup kind of work done OO NOT use retired	during most of wo	orking	16b. K	(ind of Business/I	ndustry
7	within 72 lene. than "na	Completed	Elementary/Secondary (0-12) 12th grade	College (1-4or 5+) 4yrs	me. L	Nurse	1)		The state of the s	Hospit	a 1
ב ב	il Hygid other	Be C	17. Father's Name (First, Middle, Last)	4		MALDE	18. Mother's Na	me (First, Middle	, Maider		a.L
/iand	should be ind Mental ind marked c	ToE	Joe Davis				Daisy	Jackson	n		
Mar	2 sho and I is ma		19a. Informant's Name/Relationship (Ty)	oe, Print)	19b. Mailin	g Address (Street	and Number or R	ural Route Numb	per, City o	or Town, State, Z	ip Code)
e S	s 1 and 2 should f Health and Mer item 27 is marke other traumatic		William Mack-Sor			Bonner_ sition (Name of	Road A	pt 2,	Balt	<b>imore</b> , ocation - City or 1	Md 2121
9	8 ° = 5		1 ☐ Surial 2 M Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State Metro	Crema	natory or other plac <b>LOI V</b>	3/10	/2006	Balti	more, MD	
Бащтог			21. Signature of Funeral Service License			norial   . Name and Addre		4/06	<del>'Rar</del>	<del>idallst</del>	own, Md
n	permit. Departimporti		Now 18 Und		M 4	368hw£6	H West	, Balt	imor	ce, Md	21215
		i	23a. Ps rt1. Enter the disease, ir compli	cations that caused the death.							Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	CEREBROVASC			DENT			N.	Onset and Death
**************************************	/Medical Examiner		resulting in death)	Due to (or as a consequer	nce of):						
	Laumine	<u></u>	Sequentially list conditions,	Due to (or as a consequer	202 OB:						
	nted I Insit	mine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury								
Ď	executed an and irial-transit	Examin	that initiated events resulting in death) Last	Due to (or as a consequer	nce of):						
98/91	ite be iysicia ne bur	icai		l		<u>-</u>					
	ntitica ing ph e as th	Med	IF FEMALE:						-		
gox	law requires that the death certificate be as been signed by the attending physicit 2 should be detached for use as the bu	Physician/Medica	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No	3c. If yes, outcome of pregnanc 1 ☐ Live birth 2 ☐ Fetal de 4 ☐ Pregnant at time of deal	ath 3	Ectopic pregnancy Other (specify) _	<i>'</i>			23d. Date of deli Month	very Day Year
j.	that the de ned by the a detached t	hysi	9 Unknown	9□ Unknown							
S,	es tha igned be de	by P	Part II. Other significant conditions con	tributing to death but not resulti	ng in the ur	nderlying cause giv	ren in Part I.			_	the cause of death?
Vital Records	w require been sign	Completed	HYPERTENSION	844				1	Yes 2		bbably 4 Unknown
Ş Ç	elaw hasb	mple	COLON CARCINO	MA				24a. Was		24b. Were au prior to d death?	opsy findings available ompletion of cause of
a	sician: The law certiticate has t irector, page 2 s		DEMENTIA					1 Yes	2 🗆 No		2 No
	Physician: r this certifica ral director, p	o Be	25. Was case referred to medical examiner?  1 Yes 25 No	lospital: Nationatient 2 ☐ EF	VOutpatien	t 3 DOA O#	26. Place of De	eath (Check only		6 □Other (Spec	if(v)
10	g Phy er this ieral c	-	27. Manner of Death		Bb. Time of Injury	28c. Injur	y at	28d. Describe			··y)
Š	Attending For death.  ector: Atter by the tunera	atio	Natural 5 ☐ Pending investigation	(World, Bay 1 oar)	тцигу		Yes 2 ☐ No				
DIVISION	al or Att	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At hom building, etc. (Specify)	e, farm, str	eet, factory, office		28f. Location City or To			ral Route Number,
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical (	29a. Certifier Check only one) 2 Medical Examin	sicien: To the best of my knowle ner: On the basis of examination and manner stated.	edge, death n and/or inv	occurred at the til restigation, in my o	me, date and place opinion, death occ	e, and due to the curred at the time	cause(s , date an	and manner as d place, and due	stated. to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier			29c. Licens			29d. Da	ate signed (Month	Day, Year)
	1		29b. Signature and title of certiflet			Doc	161959		FE	B 27, 2	006
	1		30. Name and address of person who co		3a) (Type,	Print)	BALTI	MORE	212	15	
J.	Sta	to.	31. Date filed (Month, Day, Year)	32. Begistrar's Signatur		A PAGE	17171		-1-		
	- 516		MAD 1 2 2	Ald "	20	acada B					

NORMA MAIDEN 3/6/06

1 - For Stata Registrar

Physician /Medical

Examiner

1. Decedent's Name (First, Middle, Last)

4a. Facility Name (If not institution, give street and number)

	<b>E</b> 3(0)111		709 Maiden Ch	oice Lane			Catons	ville		В	alto	
	Funeral Director		5. Social Security Number 151–18–8992	6. Sex 7. 1 ☐ M 2 💢 F	. Age (In yrs. Ia		f Under 1 Year Ionths Days		8. Date of Bir (Month, D) 4-24	th 19. 1917	9. Bir	thplace (State or Forei ountry) N • Y •
	pu .		Usual Residence of Decedent  10a. State 10b. Count	tv	10c. City	Town or Locat	ion					10d. Inside City Limit
	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. tiem 27 is marked other than "natural; or Items 23a or 28e-f show other traumetic event, the Medical Ever discriminative colifical at	ō				Catonsv						1 ☐ Yes 2 🖔 N
	28e-i	by Funeral Director	Md 10e. Street and Number	Balto			10f. Zip Code			10g. Citizer	n of What C	ountry?
	3a or	ō	719 Maiden C	hoice Lane	Apt 236		2122	28	:	US	A	
	death ms 2	era	11. Marital Status	12. Was Deced	ent Ever in U.S		s Decedent of H	lispanic Origin? (Sp an, Mexican, Puerto	pecify Yes or No	o- 14.		erican Indian,
ي	or Ite	Ē	1 Never Married 2 Ma	Armed Force 1 Yes 2 If Yes, Give	<b>X</b> No		Yes 25 No	Specify:	rican, etc.)		Black, Whi	
3	ural',		3 Widowed 4 □ Divorce	Year or Date	es:					,	Bla	
7	nati	Completed	15. Decede (Specify only high	ent's Education lest grade completed)		(Give kin	t's Usual Occup d of work done NOT use retired	during most of work	king		of Business	Morgan
21215-0036	12 should be filed within and Mental Hygiene. 7 is marked other than "raumetic event, the Mental Mental Control of the Mental Contro	g m	Elementary/Secondary (0-12)	College (1-4	-		ionist	-/		1		ersity
у В	filed Hygi other ent, L	ပိ	17. Father's Name (First, Middle		5			18. Mother's Nam	e (First, Middle			
o.	ld be ental ked c	To Be	Royce Potts,	Sr				Hermion	e			
Maryland	shound M	-	19a. Informant's Name/Relation			19b. Mailing	Address (Street	and Number or Ru	ral Route Numb	er, City or T	own, State,	Zip Code)
	and 2 ealth a n 27 is		Cathy D. John	nson – Daugl	hter	2001	Crestvi	ew Road	Balto,	Md 21	1239	
E.			20a. Method of Disposition	2 Demonstran St	l ce	ace of Dispositi metery, cremat	on (Name of ory or other plac		Date	20c. Loca	tion - City or	r Town, State
banimore,	Pages nent of nnt: if it		1 N Burial 2 ☐ Cremation 1 Donation 5 ☐ Other		Wo	odlawn	Cemeter	y 3-10-	-2006	Balto	Co.	Md
<u></u>	permit. Page Department of Important: If eny injury of		21. Sg ture of Funeral Service	Libensee		22. N	ame and Addre		arch F/			
0	89E 29		Make B	· Jakne	en y			Wabash Av			Md 2	
			23a. Part1. Enter the disease, shock, or heart failure. Li	or complications that cau st only one cause on eac	used the death. ch line.	Do not enter	he mode of dyir	ng, such as cardiac	or respiratory a	arrest,		Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition	My.	1tinl	ence of):	Juelo	ma.				Offset and Death
	/Medical Examiner		resulting in death)	Due to (o	r as a consequ	ence of):	7					
	, ,		Sequentially list conditions,	b								
Ī	pa sit	ine	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury	Due to (o	r as a consequ	ence of):						
	and and I-tran	Examiner	that initiated events resulting in death) Last	c. Due to (o	r as a consequ	ence of):						-
00/00	be exician					,						
000	ficate physis the	edic		O								
<b>V</b>	eath certificate be executed attending physician and for use as the burial-transit	Z	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outco						230	d. Date of de	alivery
	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	by Physician/Medical	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		th 2∏Fetal nt at time of de wn		topic pregnancy ther (specify) _	у			Month	Day Year
	res that the de signed by the a be detached f	Ph	Part II. Other significant condi	tions contributing to dea	ath but not resu	lting in the unde	ertving cause giv	ven in Part I.	23a. Did	tobacco use	contribute	to the cause of death?
Ľ,	sign d be	d by	41.000				, , , ,		1 -	Yes 2	No 3□F	robably 4 Donknow
5	v requir been s should	etec	Thomas			·			240 1460		Oth Word	utopsy findings availal
oi vilai necoru		Complete	Depression	m					24a. Wa auto	opsy ormed?	prior to death?	completion of cause of
	ician: The certificate ha								1 ☐ Yes	2 No		s 2 No
=		o Be	25. Was case referred to medic examiner?	Hospital			ott no. Ott	26. Place of Dea			70.1	
5		1-	1 Yes 2 10	28a. Date of	patient 2 🗆 E	28b. Time of	3 ☐ DOA 28c. Inju		ome 5 Res			өспу)
DIVISION	ding Ph th. After th funeral	tion	1 ■Natural 5 □ Pend	ding (Month stigation	, Day Year)	Injury	Wo	rk? ]Yes 2 ☐No				
2	l or Attending after death. Director: After	Certification:	3 ☐ Suicide 6 ☐ Coul	ld not be 28e. Place of	of Injury - At ho	me, farm, stree	, factory, office				Number or F	Rural Route Number,
2	after Direct	erti	4  Homicide	building	g, etc." (Specify	)			City or To	own, State)		
	To the Hospital or At within 24 hours after of to the Funeral Direct completely filled in by			ying Physician: To the b								
	the Ho hin 24 the Fu the Fu	Medical	(Check only 2 Madic one)	al Examiner: On the bas and manne	sis of examinat er stated.	ion and/or inves	stigation, in my	opinion, death occu	rred at the time	, date and p	lace, and du	ue to the cause(s)
	within to the comple	Ž	29b. Signature and title of certi	fier			29c. Licens	se number		29d. Date	signed (Mor	nth, Day, Year)
			Klineen	Bowle	~ : V	rus	140	Y377		3 /	17/	06
1	1		30. Name and address of person	on who completed cause	of death (Item	23a) (Type, Pr	nt)		0		, ,	Mp 2/22
1	~		Denecu Bou	lin, mo	711 1	naide	in Ch	oice hu	re, Car	tensi	rille	MD 2/22
		ate	31. Date filed (Month, Day, Yea	ar) 32. R	gistrar's Signat	ure A	and s				ι	
	Regist		MAR 1	_a ZUUb	AND S	S AND						
DH	MH 17 Rev 1/	2001		· · · · · · ·		100						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

4b. City, Town, or Location of Death

2. Date of Death Month

Year O O

4c. County of Death

6:00 pM

9. Birthplace (State or Foreign

DHMH 17 Rev 1/2001

Registrar

3 2006

_			1 - For State Registrar	State of Ma	aryland			of Health of Deatl		lental Hy	giene	006	07	546
	Physici	an	1. Decedent's Name (First, Middle,							2. Date of De	eath Day	Yea		e of Death
	/Medic	al	Edward	Lee		Moore			1.D	03	10	2000		22 AM
	Examin	er	4a. Facility Name (If not institution, s	A HACOLT	1/		BARA	vn, or Location	or Death		1.	County of De	MOVE	Δ.
	Funeral				In yrs. la	ast birthday)	If Under 1 Y		er 24 Hrs.	8. Date of Bi (Month, D	rth	9. 8	irthplace (Sta	ate or Foreign
	Director		218-26-4869	M 2□ F	7	75 Yrs.	Months Da	ays Hours	Min.	June 2	, 193	30 M	arylan	d
	and		Usual Residence of Decedent  10a. State 10b. County		10c. City	. Town or Loc	ation						10d Insid	e City Limits
	the Marylar 28a-f ahow	lor	Maryland Baltim	ore	Di	ındalk								res 2X∏No
	r 28a	lrec	10e. Street and Number				10f. Zip Cod	de			10g. Citi:	zen of What	Country?	
	deeth with the Maryland ma 23a or 28a-f ahow rmust be notified at	Funeral Director	74 Avalon Avenue				2122	22			US	SA		
i	tema tema	uner	11. Marital Status	12. Was Decedent E Armed Forces?		5. 13. W	/as Decedent Yes, specify (	of Hispanic C Cuban, Mexic	rigin? (Spi an, Puerto	ecify Yes or No Rican, etc.)	0-	4. Race - Ar Black, W	nerican India	٦,
7	rs afte	by F	1 ☐ Never Married 2 ☐ Married 3 ② Widowed 4 ☐ Divorced	1 ☐ Yes 2X N If Yes, Give Year or Dates:	lo	1	☐Yes 2【文	No Specif	y:			Specify: W	nite	
Nard	2 hou	ted	15. Decedent's	Education		16a. Deced	ent's Usual O	ccupation				nd of Busines		
215	ithin 7 19.	Completed	(Specify only highest s Elementary/Secondary (0-12)	College (1-4or 5	+)	life. D	O NOT use re	one during mo etired)	ost of work	ing				
Ward	iled w tygier thar th	Cor	8 years 17. Father's Name (First, Middle, La	ctl		Sea	men	10 1401	hada Nami	e (First, Middle	<del></del>		Marine	
and	d be f antai h ced of c ave	o Be	Theodore A. Moor							Koing	, мала <del>е</del> п	Surname)		
- <u>F</u>	should nd Me nmark	To	19a. Informant's Name/Relationship			19b. Mailing	Address (St			al Route Numb	per, City or	Town, State	, Zip Code)	
00Y€, ore, Mary	and 2 valith a 27 is		David Moore	son		3274 \	ork St	reet,		nester,				
MOVYE, $Ed$	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryla Depertment of Health and Mental Hygiene. Importent: if Item 27 ia marked other then "natural", or Itema 23a or 28a-1 shov any injury or other traumatic event, the Medical Examinar must be notified at one.		20a. Method of Disposition 1 ဩBurial 2 ☐ Cremation 3	rial 2 □ Cremation 3 □ Removal from State Meadowridge Ce, etery 2									or Town, Stat	
三龍	t. Pag ntment rtent: njury		4 Donation 5 ☐ Other (Spe	cify)	- marine -	2006				e, Mar	yland			
Bal	Depermine Depermine Important in important ir gang		21. Signature of Funeral Service Lic	ensee)	me Of Road,	Dunda	lk,P.	A. 2122	2					
			23a. Part1. Enter the disease, or co shock, or heart failure. Use on	mplications that caused	the death.							LINITID	Approxi	
	Physician		Immediate Cause (Final disease or condition	Din Allim	nni A								Onset a	nd Death
	/Medical Examiner		resulting in death)	Due to (or as a	a consequ	ence of):								
	ZXXIIIII	<u>_</u>	Sequentially list conditions,	b. Due to (crass	1.0015300	ence of								
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to initial data cause. Enter Underlying Cause (Disease or injury that initiated events	c.	·									
0,	ate be executed thysician and the burial-transit		resulting in death) Last	Due to (or as a	a consequ	ence of):								
8760,	cate be chysicia the bur	dlcal		d										
9 X 6	eeth certifica ettending pl for use as t	/Me	IF FEMALE:	23c. If yes, outcome of	of pregnar	icv					1	3d. Date of c	lolinon	
B	deeth e etter d for u	Iclar	23b. Was decedent pregnant in the past 12 months?	1☐Live birth 4☐Pregnant at	2 🗌 Fetal	death 3 □	Ectopic pregna Other <i>(specif</i> )				-	Month	Day	Year
P.0	that the deeth certific ed by the ettending p detached for use as	Physician/Med	9 🗆 Unknown	9 Unknown										
Division of Vital Records, P.O. Box 6	Attanding Physician: The law requires that the death certifical rideath.  croath.  ector: After this certificate has been signed by the ettending phy by the funeral director, page 2 should be detached for use as the		Part II. Other significant conditions Who imass	contributing to death bu	ıt not resu	lting in the un	derlying cause	e given in Parl	H.			se contribute	to the cause	of death?
orc.	w requires to been signer should be	etec	(100)											
Rec	he fav	Completed by	Alria Librilla	lin.o						24a. Was auto perfe		24b. Were prior t death	autopsy findir completion	ngs available of cause of
tal	ician: Th certificate ector, pag	0	25. Was case referred to medical	tion				26 Plac	e of Death	1 Yes		1 □ Y	es 2 No	
<u> </u>	Physici this cer al direc	To B	examiner?	Hospital: 1 Inpatier	nt 2 🗆 E	R/Outpatient	3□ DOA	Othor		me 5□Res		Other (Sp	pecify)	
0	ding Pl		27. Manner of Death  1 ☑ Natural 5 ☐ Pending	1 Natural 5 ☐ Pending (Month, Day Year) Injury Work?										
isio	uttandi death. ctor: A y the fu	Icat	3 Suicide 6 Could not	be On Diago of Inju	Inv - At hor	no form stro				28f. Location (	Ctroot and	( Alumbor or	Rural Route I	l
Div	al or A after i Dire d in by	Certification:	4 Homicide determine	building, etc	. (Specify)	)	et, ractory, on	lice			wn, State)	I VUITIDEI OI	nurar nobie r	vurn <i>ber</i> ,
	To the Hospital or Atlanding Physician: The within 24 hours after death.  To the Funeral Director: After this certificate his completely filled in by the funeral director, page	edical (	29a. Certifier 1 Certifying (Check only one)	Physician: To the best of aminer: On the basis of and manner sta	examinati	rledge, death on and/or invi	occurred at the	ne time, date a my opinion, de	and place, eath occurr	and due to the ed at the time,	cause(s) date and	and manner place, and d	as stated. ue to the cau	se(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	JHY BENDE		N. M		cense number			29d. Date	signed (Mo	nth, Day, Yea	r)
	d		I'm	2.17 130 - 70		, ,,,,		RESO	000		3)10	06		
	18		30 Name and address of person wh	o completed cause of de	ath (Item	4	1 1 1 1 1	21,01-1	Kriv	e Bal	to a	11 -	1120-	1
	Sta	te	31. Date filed (Month, Day, Year)	32. Registra	Signati		Klinsq	flure	OFIV	THI	10, 1	10 0	1120	
	Registr		MAR	1 3 2006	Pares	M	Board	P. B.						

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Metalios Peter March 10, 2006 ear **Physician** 3:10 A M /Medical 4c. County of Death 4a. Facifity Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Gilchrist Center Towson If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Days Hours Min. Dec. 17, 1916 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 M M 2 □ F 89 086-01-6763 New Hampshire Director Peter Metalios March 10,2006
Baltimore, Maryland 21215-0036 Usual Residence of Decedent 10a. State Maryland 10c. City Town or Location Baltimore 10d. Inside City Limits "natural", or Items 23a or 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryla Department of Health and Mental Hygiene. Important: if Item 27 is marked other then "natural", or Items 23a or 28a-1 showing Injury or other traumatic event, the Medical Examiner must be notified at once. 1 Yes 2 No Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21214 U.S.A. 3206 Berkshire Road Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Maritaf Status 1X∑Yes 2 □ No ff Yes, Give Year or Dates: WW II 1 Never Married 2 Married 1 ☐ Yes 2 🙀 No Specity: White ð 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary (Secondary (0-12) College (1-4or 5+) Bar / Restaurant Bartender 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Metalios Evangelia Jolas Vaio 19a. Informant's Name/Relationship (Type, Print) Margo Metalios Marck -19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11311 Notchcliff Rd. Glen Arm, MD 21057 Daughter 20b. Place of Disposition (Name of Date 20a. Method of Disposition 20c. Location - City or Town, State cometery crematory or other place) Greek Cemetery 1 XBurial 2 Cremation 3 Removal from State 3/13/06 Baltimore, MD 4 □Donation 5 □Other (Specify)

21. Signatury of Fineral Service Ligensee 22. Name and Address of Facility Baltimore, MD 21214 5305 Harford Rd. Leonard J. Ruck, Inc. Harboch 10 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) farlure **Physician** /Medical Due to (or as a consequence of): nephroschewsis Examiner perfersive Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to or as a consequence of): The law requires that the death certificate be executed. physicien and s the burial-transit Due to (or as a consequence of): Box 68760. Physician/Medical signed by the attending p d be detached for use as 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death P.O. 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. ģ 2 No 3 Probably 4 □Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autops, performed: To the Hospital or Attending Physician: The within 24 hours attendeath. To the Funeral Director: After this certificate I completely filled in by the luneral director, page 1 Yes 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 103 Pi 4 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Certification: 27. Manner of Death 28c. fnjury at Work? 28d. Describe how injury occurred 5 Pending investigation Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 🖺 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number March 10 2006 58303 30. Name an vaddress of person who completed cause of death (Item 23a) (Type, Print) 6601 N. Charles St Byvinice no 21204 Armon Charles, ans 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

**ORIGINAL** 

			For State Registrar	State of M	laryland / De		of H	ealth a		ental Hy		2006	0751	, 9
	Physici /Medi		Decedent's Name (First, Middle, Lass	Larry T.	Monard					2. Date of Dea Month March		<sup>Day</sup> 2006 Year	3. Time of 12:47	Death PM
	Examir		4a. Facility Name (If not institution, give Montgomery Hospic			R	ockv	Location o				4c. County of Death		
	Funeral Director		5. Social Security Number 6. Security Number 215-46-0116	9x 7. A ⊠M 2□ F	ge (In yrs. last birthda 57 Yrs	Months	1 Year Days	II Under: Hours	24 Hrs. Min.	8. Date of Birt (Month, Day March 12	h v, Yea	9. Birth Cou 1948 Wash	ptace (State or intry) ington,	Poreign D.C
	Maryland	tor	10a. State 10b. County  Maryland Montgome	ery	10c. City, Town or	Location	ille						10d. Inside Cit	
	th with the 23a or 28s	Funeral Director	10e. Street and Number 1018 Scott Avenue	2		10f. Zip		20851			-	Citizen of What Cou		
036	72 hours after death with the Maryland Instural; or Items 23s or 28s-f show Idical Exemitiver must be ricitified at	þ	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☐ Widowed 4 ☒ Divorced	12. Was Deceden Armed Forces 1 X Yes 2 If Yes, Give Year or Dates	Everin U.S.   1   Po   Vietnam	3. Was Decedi If Yes, spec		spanic Orig n, Mexican Specify:	gin? (Spe i, Puerto I	crfy Yes or No- Rican, etc.)		14. Race - Ameri Black, White Specify:		
1215-0	within 72 ho ane than "natur is Medical I	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12) 1 2	ucation de <i>completed)</i> College (1-4or	(G life	cedent's Usua ive kind of won e. DO NOT us core Mat	k done d e retired,	uring most )	t of workir	ng		Kind of Business/Ir		
land 2	uld be filed v fental Hygie rked other i iic event, E	To Be Co	17. Father's Name (First, Middle, Last) Thomas Harry Mor	nard		ore na	lage			(First, Middle,	Maide	en Sumame)		
, Mary	and 2 shouealth and No. 127 is maine		19a. Informant's Name/Relationship (7 Joseph A. Monard/I		6914	Alex	Cour		eder	ick, Ma	ary	or Town, State, Zi 1and 2170	)3	
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Exercities must be notified at ance.		20a. Method of Disposition  1 □ Burial 2 ☒ Cremation 3 □  4 □ Donation 5 □ Other (Specify  21. Signature of Funeral Service Licen.	)	' Montgom Cremato	erg ery rium, I	nc .		Marc 200		Ве	thesda, Mome/Rockviille, MD	lary1an	
*	Physician /Medical Examiner	ner	23a. Part1. Enjer the disease, or compshock, or heart failure. List only of immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	a	d the death. Do not	enter the mode						ille, MD	Approximate Interval Betwoonset and D	veen
). Box 68760,	s death certificate be executed the ettending physicien and ed for use as the burial-transit	Physician/Medical Examiner	Lause (Disease or Injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No	d23c. II yes, outcom 1 □ Live birth	2 Fetal death	3 □Ectopic pre 5 □ Other (spe						23d. Date of deliv	,	ear
ords, P.O.	Physician: The law requires that the death certifica this certificate has been signed by the ettending phraid director, page 2 should be detached for use as it.	by	9 ☐ Unknown  Part II. Other significant conditions co		but not resulting in the	e underlying ca	iuse give	n in Part I.		1 🗆 Y	'es	o use contribute to t	he cause of debably 4	
Division of Vital Records,	en: The law tificate has b tor, page 2 s	e Completed	25. Was case relerred to medicat					26 Place	of Death	24a. Was a autop perfor 1 Yes	sy med? 2 1 N	death?	opsy findings a empletion of ca 2 No	
کر کر	hysici this cer al direc	ToB	1 195 221N0		ient 2 ER/Outpat			r: 4 🗆 Nut	rsing Hon	ne 5 Resid	ence	6 ⊠Other (Speci	<sub>fy)</sub> Hospi	ce
vision	Attending ir death. ector: Afte by the fune	Certification:	27. Manner of Death  1 XNatural 5 Pending investigation  3 Suicide 6 Could not be determined	286. Place of ir	ay Year) Injur	м		at ? ′es 2 ☐ N	No	8d. Describe h	treet a	and Number or Run	al Route Numb	per,
٥	To the Hospital or within 24 hours after To the Funeral Dir completely filled in	edical Cert	29a. Certifier 1 ★ Certifying Phy (Check only 2 → Medical Exam	vsician: To the bes	t of my knowledge, de of oxamination and/or	eath occurred a	it the time	e, date and	d place, a	City or Tow	ause(	(s) and manner as s	stated.	-
ŀ	To the within 2 To the complet	Med	29b. Signature and title officertifier	and manner s	MAN		License				29d. D	oate signed (Month, arch 8, 2	Day, Year)	
10	+ 4		30. Name and address of person who of Joseph Kaplan, M.I	6001	Muncaster		oad,	Rock	vill	e, Mary	/1ai	nd 20855		
DH	Sta Registr MH 17 Rev 1/20	ar	31. Date filed (Month, Day, Year) MAR 1 3 20	48	rar's Signature	barte								
						GINAL								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) Year **Physician** MARCH 8 2006 MISHKIN 9:15A /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner JEWISH CONVALESCENT CENTER BALTIMORE BALTIMORE If Under 1 Year If Under 24 Hrs. 8. Date of Birth
JUL. 10, 1916 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min 1 □ M 2 🖁 F 89 Yrs 286-10-1541 Director Usual Residence of Decedent 10b. County 10c. City. Town or Location 10d. Inside City Limits 10a State al Hygiene. Lother then "natural", or Iteme 23a or 28a-1 ehov event, tre Medical Exercites roust be notified at 1 No Yes 2 No Director BALTIMORE MD N/A 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? NORTHERN PARKWAY #716 21210 USA 1190 W. by Funeral filed within 72 hours after death . Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 WHITE 1 ☐ Yes 2 🛣 No Specify: 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) 4 ACCOUNTANT ACCOUNTING 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 Is marked oth any injury or other traumatic event QDCB. Be **PEARLMAN** LEPAR SAMUEL W. ALMA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6101 PARK HEIGHTS AVENUE #1-H BALTIMORE, MD 21215 SAMUEL ARNOFF / SON 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 🕅 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) NETANYA CEMETERY 03/10/2006 NETANYA, ISRAEL 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition **Physician** (ancer resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, it is a cause. Enter Underlying Cause (Disease or injury Examiner Due to [or as a consequence of] or Attending Physician: The law requires that the death certificate be executed use as the burial-transit that initiated events attending physicien and for use as the burial-tran resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Medical Certification: To Be Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown s been signed by the should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Minknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate 2□ No 21 No 1 Tyes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 44 Nursing Home 5 Residence 6 Other (Specify) 2 100 1 Inpatient 1 Tyes 2 ER/Outpatient 3 DOA SIL After thi 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No naral Director: A filled in by the fu 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 90

State

Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)
MAR 1 3

Raymona Miller

Gummer

Mille

2006

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Man

Registrar's Signature

Old CHEN I

warded

29c. License number

Rustustown

D4768

MD

21136

29d. Date signed (Month, Day, Year)

3/8/06

			1 - For State Registrar	State of Ma	ryland / Dep <i>Ce</i>	artment of F rtificate of			giene     Reg. No.	Ub	0/551
П	Physici	an	1. Decedent's Name (First, Middle, Las	•				2. Date of Dea Month	ath Day	Yeer	3. Time of Death
	/Media	al	4a. Facility Name (If not institution, give	num ford		4h City Town o	r Location of Death		4c Coun	ty of Deeth	845 PM
	Examin	er		, Care Cente	7	Ba 140			10000	,, 0. 200	
	Funeral Director		5. Social Security Number 6. Sec. 218-32-3/97		(In yrs. last birthday) FO Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day	h Year) 35	9. Birthp Cour	lace (State or Foreign try)
	land ow		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or Le	ocation				1	0d. Inside City Limits
	Mary a-f sh	tor	MD Baltim	Re	DUNCO	UK					1 □ Yes 2 ☑ No
	or 28	Jirec	10e. Street and Number	1		10f. Zip Code			10g. Citizen o	f What Cour	ntry?
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2-0	72 ho natur	Completed	15. Decedent's Ed (Specify only highest gra	ucation de completed)	16a. Dece (Give	dent's Usual Occup	nation during most of work d)	king	16b. Kind of	Business/In	dustry
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Maryland	2 should be and Mental Is marked of sumatic eve		19a. Informant's Name/Relationship (7			ng Address (Street	and Number or Rui	ral Route Numbe	r, City or Tow	n, State, Zip	Code)
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Baltimore,	Pages 1 nent of H int: If Ite ury or ot		20a. Method of Disposition  1 Burial 2 Cremation 3		20b. Place of Disponentery, cre	, /	ce)	-/-	20c. Logation	1 - Oily of To	/ State
	permit. Page Department Important: If any injury or once.		<ul> <li>4 □ Donation 5 □ Other (Specify</li> <li>21. Signature of Fugeral Service Licen</li> </ul>	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	OTAM SON	Name and Addre	ss of Facility	5/06	OWNGS	Mill	SIMO
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	pitel ours a erel [		29a, Certifier 1 Certifying Ph	reician: To the hest	of my knowledge, dea	h occurred at the tir	mo date and place	and due to the	cause(s) and	22 20000	tated
	To the Hospitel or Attending Physician: within 24 hours after death. To the Funerel Director: After this certifical completely illed in by the funeral director.	Medical			examination and/or in						
	To th within To th compl	Me	29b. Signature and title of certifier			29c. Licens			29d. Date sign	ned (Month,	Day, Year)
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5	\		30. Name and address of person who	completed cause of d	eath (Item 23a) (Type	Print)	11	MO 3 1			
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معر	И			to completed cause of a	2 M	23a) (Type,	el- 1	Place	2 00	ustali	e al	<b>)</b> 2	21222
	Sta Regist		31. Date filed (Month, Day, Year) MAR 1 3 20	06 32. Registr	ars Signa	ture							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 Date of Death 1. Decedent's Name (First, Middle, Last) Month 3 **Physician** Dorothy Naomi Prato /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner quare anklin 8. Date of Birth (Month, Day, Year) July 16,2006 5. Social Security Number Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 M XXF 508-16-3567 Yrs. 83 Nebraska Director Usual Residence of Decedent 10c. City. Town or Location 10a, State 10b. County 10d. Inside City Limits or items 23s or 28s-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes XX No Completed by Funeral Director Middle River Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21220 2159 Redthorn Road U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 🏖 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ Xo Specify: Specify: %™ Widowed 4 □ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Depertment of Health and Mental Hy Important: if Item 27 Ie marked oth exp joint yor other traumatic event 90ce. Katherine McNeil Francis Cumpston 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1033 Sedgewood Place Court, Charlotte, N.C. 28211 Nicholas J. Prato (Son) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Surial 2 ☐ Cremation 3 ☐ Removal from State Sacred Heart Of JesusMarch 14,2006 Baltimore, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Ski Funeral Home, P.A. 21. Signature o uneral service Licensee 1407 Old Eastern Avenue, Essex, Maryland 21221 23a. Part Errier the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, show, or heart failure. List only one cause on each line. Approximate Interval Between O et and Death Imm diate Cause (Final disea or condition resulting in death) MYOC **Physician** MOU! /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy Month 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, À 1 Yes 2 No 3 Probably 4 Munknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1 Yes 2 or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Inpatient Medical Certification; To 2 ER/Outpatient 3 DOA 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manger of Death 1 Natural 2 Accident after death. 5 Pendina 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by within 24 hours after or To the Funeral Direc completely filled in by 4 🗍 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mainteness of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 20. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jr. EL H H W 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

State

Registrar

**ORIGINAL** 

fresh

32. Registrar's Signature

			For State Registrar	State of Maryland	/ Depa		of He	alth ar				06	07554
1 意	Physici /Medio		1. Decedent's Name (First, Middle, Last PATRICIA A	. PRESTON		4 C T			M	Date of Dea Month Arch	10 Day	2006	3. Time of Death 5:33 at
	Examin Funeral Director	er	4a. Facility Name (If not institution, give HOMEWOOD NURS 5. Social Security Number 6. S 215-68-5649	ING CENTER	birthday) Yrs.	If Under 1	TIM(		4 Hrs. 8	Date of Birth (Month, Day FEB 2	Year)	Co	thplace (State or Foreign
	49 - 176	tor	Usual Residence of Decedent  10a. State 10b. County	10c. City, To		cation EWOOI	)			тир 2	<i>,</i> 1. <i>)</i>	J2; 1111	10d. Inside City Limits 1 ☐ Yes 2 🛣No
	within 72 hours after death with the Maryland ene. than "natural", or itema 23a or 28a-f ehow ta Madical Exercion in inval be motified a	Funeral Director	10e. Street and Number  803 C WINDSTRI  11. Marital Status	EAM WAY		10f. Zip (	210		in? (Speci	fy Yes or No-	U	en of What Co S.A. 4. Race - Ame	erican Indian,
-0036	2 hours after a atural', or ite	by	1 Never Married  3 Wildowed 4 Divorced  15. Decedent's Ec		6a. Dece	1 □ Yes 2	Occupatio	Specify:				Black, White Specify: BL	ACK
d 21215-0036	be filed within 72 ho ntal Hygiene. od other than "natur event, La Mudical	e Completed	(Specify only highest grade  Elementary/Secondary (0-12)  12th grade  17. Father's Name (First, Middle, Last)	College (1-4or 5+)	life. I	kind of work DO NOT use EMPI	retired) LOYE	D		First, Middle,	Maiden S	N/A	
Maryland	should and Mer smarke aumatic	To Be	ALFRED ALEXANI  19a. Informant's Name/Relationship (	Type, Print) 1				d Number	or Rural F		r, City or	Town, State,	
Baltimore, I	Pages 1 an nent of Heal ant: if Itam 2 ury or other		GIOVANTAY JARV  20a. Method of Disposition  1XXIII 2 Cremation 3 C  4 Donation 5 Other (Specify	Removal from State	of Dispo etery, crer	C. V sition (Name natory or oth CEME	e of ner place)	İ	Dat		20c. Loc	ation - City or	Md 21040 Town, State ON, MARYLAN
Balt	permit. Pag Department Important: eny injury o		21. Signature of Funeral Service Licer  21. Signature of Funeral Service Licer  22. Part 1. Enter the disease, or com	Brown  Discations that caused the death. D	3 So not ent	Name and M C I	Address ROW PHI of dying,					RAL H	OME-HARFOR D 21001 P.
	Physician /Medical Examiner		shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. AID S		GCT1	00'						Interval Between Onset and Death
8760,	death certificate be executed e attending physicien and for use as the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence.  Due to (or as a consequence.	ce of):								
P.O. Box 68	at the death certificat by the attending phy tached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal dea 4 Pregnant at time of death 9 Unknown	ath 3□	Ectopic pre					23	3d. Date of de Month	livery Day Year
	The law requires that the site has been signed by the bage 2 should be detached.	by	Part II. Other significant conditions c	ontributing to death but not resultin	g in the u	nderlying ca	use given	in Part I.				/	o the cause of death? robably 4 DUnknown
of Vital Records,		e Completed	25. Was case referred to medical				2	% Place o	of Death (		med? No	prior to death?	utopsy findings available completion of cause of
ion of Vi	ling Phy	ation: To B	examiner?  1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year) 28t	Outpatient b. Time of Injury		Other: c. Injury a Work?	4 Nurs	sing Home		ence 6	Other (Spe	icify)
Division		il Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At home building, etc. (Specify)  ysician: To the best of my knowled				date and		City or Tow	n, State)		ural Route Number.
	To the Hospital or within 24 hours after To the Funeral Dir completely filled in	Medical	(Check only 2 Medical Examone)  29b. Signature and title of certifier	niner: On the basis of examination and manner stated.	and/or in	vestigation, i	License r	number	occurred	at the time, o	date and	signed (Mont	th, Day, Year)
,	27		(Check only 2 Medical Example)  29b. Signature and title of sertiler  30. Name and address of person who 6 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	MAN NAING Completed cause of death (Item 23)	a) (Type,	Print)	Hon	18000	QCSC MT	M 1 GEN	1ARC SESI	4 13; 5 Nu	RSING (3N7C)
5.0	Sta Registr	te ar	31. Date filed (Month, Day, Year)  MAR 1.3	32. Registrar's Signature	A	ande		1		010	0		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend item 19a per fh 853 3-13-06 vt
State of Maryland / Department of Health and Mental Hygiene
Amend item 20b per fh 853 3-17-06 vt
Certificate of Death

Rag, No. 0 6 1 - For State Registrat Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** SANDRA BELL PALMER 19:11 PM MAR 2006. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner N/A Baltimore Baltimore Hospital 0 Simai If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral 1 □ M 2 □XF 50 219-62-4515 Director 07/21/1955 MARYLAND Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Maryland 28a-f show treumatic event, the Medical Examiner must be notified at ¥Yes 2 No MD N/A Director BALTIMORE CITY 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 0 17 S. ROSEDALE STREET Items 23a 21229 USA Funerai 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 X Married ö Baltimore, Maryland 21215-0036 1 ☐ Yes X No Specify If Yes, Give Year or Dates: Specify: BLACK Completed by 3 Widowed 4 Divorced "natural" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 12 should be filed within 7 h and Mental Hygiene.
7 Is marked other than "n OBER, KALER, GRIMES Elementary/Secondary (0-12) College (1-4or 5+) SHRIVER CORP. WORD PROCESSOR 12TH YEARS 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be JAMES BELL BEATRICE LEE ၉ 19a. Informant's Name/Relationship (Type, PTYAUGHTER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) , 1 and 2 si of Health ar MAISHA M. PALMER/DAUGFHTER 24 SPECTATOR LANE OWINGS MILLS, MD 2 21117 other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 16 ate Pages nent of I permit. Pages Department of Important: If It any injury or o Burial 2 Cremation 3 Removal from State 3/17/06WINDSOR MILL, MD KING MEM. PARK 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility HOWELL FUNERAL HOME 21207 by the disease, or complications that caused the dearn. Do not enter the mode of dying, such as cardiac or respiratory arrest, leart failure. List only one cause on each line. 4600 LIBERTY HEIGHTS AVE, BALTIMORE, Approximate Interval Between Onset and Death Immediate use (Final diseas condition PNEUMONIA Physician ASSIRATION /Medical resulting in death) Due to (or as a consequence of) Examiner JAK CHE NTESTINAL OBSTRUCTION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-transit resulting in death) Last Due to (or as a consequence of): attending physicien Physician/Medical the IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No ō Month Year Day 4 Pregnant at time of death 5 Other (specify) the 9 Unknown à signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۵ þ 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an page 2 s certificate has autopsy 2 No 1 Yes or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To Sinis 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After

Box 68760 P.O. Division of Vital Records.

Palmex Sandag

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To the Hospitel c within 24 hours at To the Funerel DI

death.

Director: /

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State

Registrar DHMH 17 Rev 1/2001

Medical

MP

5 Pending

investigation

6 Could not be determined

ES-000

1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

1 Yes 2 No

29d. Date signed (Month, Day, Year) MARCH 10 2006

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SINAI OF BALTIMOPE MD HOSPITAL VIVER KUMAR 32 Registrar's Signature-

Injury

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

31. Date filed (Month, Day, Year)

1 Natural

2 Accident

3 Suicide

29a. Certifier

4 Homicide

(Check only one)

29b. Signature and title of certifier

Certificate of Death

3. Time of Death

9. Birthplace (State or Foreign

10d. Inside City Limits

1 Yes 2 No

Missouri

Day

@ hare

29d. Date signed (Month, Day, Year)

3/10/06

240 AM

Year

State Registrar 31. Date filed (Month, Day, Year) MAR 1 3 2006

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier



AU417643517099

		1 - For State Registrar	State of Marylar	•	nt of Health and te of Death		iene	07557
Physic /Med		1. Decedent's Name (First, Middle, Last	PEPPLER		~	2. Date of Death Month	100 00	3. Time of Death
Exami	ner	4a. Facility Name (If not institution, give  Johns Hopkins Box  5. Social Security Number 6. Se.	yview Medic	al Center	Balt More		4c. County of Death	place (State or Foreign
Funeral Director		213-40-7745  Usual Residence of Decedent	MM 2□F 64	4 Yrs. Months			1942 Was	hington, DC
he Marylar 8a-f show	Director	Maryland Howard		ty, Town or Location	Ellicott			10d. Inside City Limits 1 ☐ Yes 2 🛣No
th with the 23e or 2	ai Dire	10e. Street and Number 8506 Harvest V	iew Court	10f. Zip	21043	10	og. Citizen of What Cou USA	ntry?
-0036 hours after deeth with the Maryland tural; or Items 23s or 28s-1 show at Examiner must be notilised at	by Funeral	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☐ Widowed 4 ██Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates:	I.S. 13. Was Dece If Yes, spe 1 ☐ Yes	dent of Hispanic Origin? (confry Cuban, Mexican, Pues X	Specify Yes or No- to Rican, etc.)	14. Race - Ameri Btack, White, Specify:	
21215-0036 ad within 72 hours af giane. er than "natural", or than Madical Exkin	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	cation s completed) College (1-4or 5+)	16a. Decedent's Usu (Give kind of wo life. DO NOT u Securit	ork done during most of worse retired)	orking	State Gove:	ndustry
land Id be file ental Hy ked outh	To Be Co	17. Father's Name (First, Middle, Last)  Joseph Patrick		Securit	18. Mother's Na	me (First, Middle, M		rniient
C = '4 F		19a. Informant's Name/Relationship (Ty Douglas P. Pepp	,		ogan Street	ural Route Number,		Code)
- S 0		20a. Method of Disposition  1 Burial 2 XCremation 3 F  4 Donation 5 Other (Specify)	lemoval from State	Place of Disposition (Na cemetery, crematory or c tro Cremato	me of other place)  ry, Inc. 3/1		20c. Location - City or T Baltimore	
Baltimo permit. Page Department of Important: If any Injury or			gorchik	22. Name at 299 F:	<sup>nd Address of Facility</sup> Cr rederick Roa	remation S d Baltim	ore. MD 212	
Physician /Medical Examiner	ner	23a. Part1. Enter the disease of or complishook, or heart failure. List only or timmediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence)  Due to (or as a consequence)  Due to (or as a consequence)	rebralluence of):	remon hage	c or respiratory arre	st,	Approximate Interval Between Onset and Death 3 days
'8 /6U, cate be executed obysicien and the burial-transit	dical Examiner	Cause (Disease or injury that infilated events resulting in death) Last	Due to (or as a conseq	juence of):				
death certifi death certifi e attending I d for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d	ıl death 3 ⊟Ectopic p			23d. Date of deliv Month	ery Day Year
cords, F.O. w requires that the been signed by the should be detached	þ	Part II. Other significant conditions cor	ntributing to death but not res	ulting in the underlying o	eause given in Part I.	23e. Did tob	acco use contribute to t	. 1
I KeC The law ete has b page 2 s	Completed					24a. Was ar autopsy perform 1 Yes 2	prior to co	opsy findings available impletion of cause of
Or VICAL P Physicien: Th this certificete ral director, pag	To Be	25. Was case referred to medical examiner?  1 Yes 2 No	lospital:	ER/Outpatient 3□ D0	Other	ath  Check only one	nce 6 □Other (Specia	6/1
VISION OT Attending Physic death. sctor: After this by the funeral di		27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)		28c. Injury at Work? 1 Yes 2 No	28d. Describe ho		
를 들었다.	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Ptace of Injury - At h building, etc. (Specif	ý) 		City or Town,		
ne Hospitel n. 24 hours a ne Funerel bletely filled	Medical	29a. Certifier (Check only one)  Certifying Physical Exemination (Check only one)	sician: To the best of my kno ner: On the basis of examina and manner stated.	owledge, death occurred tion and/or investigation	at the time, date and plac , in my opinion, death occ	e, and due to the ca urred at the time, da	use(s) and manner as s te and place, and due to	stated. o the cause(s)
To the within To the comple	W	29b. Signature and title of certifier	U.	MD PhD 29	Les -600	29 <b>/</b> 7	d. Date signed (Month,	Day, Year) 2006
10		30. Name and address of p rson who co Carolyn A. Cronin,	mpleted cause of death (Item Bryview Medic	n 23a) (Type, Print)	Res-600 1940 Easter	n Avenue	, Bultimore	MD 21224
St Regist	ate rar	31. Date filed (Month, Day, Year)	2. Registrar's Signa	ture			1	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene | | | | 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Year \_a <sup>™</sup> Lamberto Paci March 11, 2006 9:30 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Pikesville
If Under 1 Year | If Under 24 Hrs. 713 Cliffedge Road Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 117 M 2□ F Yrs. Director 92 160-14-1962 Dec 13, 1913 Pennsylvania Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits or than "natural", or Items 23a or 28a-f show Director 1 ☐ Yes 2 No MD Baltimore Pikesville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 713 Cliffedge Road 21208 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Year or Dates: 43-46 Specify: 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. int: if item 27 is marked other than ' Elementary/Secondary (0-12) College (1-4or 5+) 12 Supervisor Post Office other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Giulio Paci Assunta Guazzaroni 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bernice Paci Wife 713 Cliffedge Road Pikesville, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State ō Department of Important: If any injury of once. ` 4 ☐ Donation 5 ☐ Other (Specify) Carroll Cremation Set. 3/13/06 Hampstead, MD 22. Name and Address of Facility 11824 Reisterstown Road ins ELINE FUNERAL HOME Reisterstown, MD 23a. Part1. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Artoniosclarotic Zoyeans disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examiner Dua to (or as a nonsequence of) cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of): physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Year Month Day 4 Pregnant at time of death 5 Other (specify) P.O. the 9 Unknown à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Be Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes No 1 ☐ Yes or Attending Physician: funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1

Yes 2 □ No this 28a. Date of Injury (Month, Day Year) Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 Pending after death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 \ Homicide within 24 hours a To the Funeral [ 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title o certifier 29d, Date signed (Month, Day, Year) 018667

DHMH 17 Rev 1/2001

State Registrar Hill CT. Eutherville, MD

cause of death (Item 23 (Type, Print)

32. Bygistrar's Signature

		For	State of Ma	aryland	d / Depa	artment	of He	alth a	nd Men	tal Hygie	ene			
		1- State Registraramend Item	#8 Per FH	G853	3/99/	rtifica <del>te</del>	of D	eath			NO 006	075	59	
Physic /Medi		1. Decedent's Name (First, Middle, Last William Anthony P	•	•					Ma	Date of Death Month Ch 11	Day Year 2006	3. Time of 8:35	Death A M	
Exami	ner	4a. Facility Name (If not institution, give	· ·			4b. City, To		ocation of	Death		4c. County of De			
Funeral		Franklinwood Nurs 5. Social Security Number 6. Se		e (In vrs. la	ast birthday)	Rose		If Under 24	4 Hrs.   8 F	ate of Birth	Baltimor		r Coroina	
Director			XM 2□F	90	Yrs.			Hours	Min. 12	Month, Day, Y /30/ <del>20(</del>	9. Bi 06 1915 Ma	ryland	r roreign	
yland	1.	10a. State 10b. County			Town or Lo							10d. Inside Ci	ty Limits	
Ba-1 •	cto	MD N/A		Ba	ltimor	,e						¹ÆXYes	2 ☐ No	
with the	Funeral Director	10e. Street and Number				10f. Zip C				10g	. Citizen of What C	ountry?		
death me 23	era	5722 Onnen Rd.	12. Was Decedent	Ever in U.S	13 1	2120		anic Origi	n? (Specify	Ves or No-	USA 14. Race - Am	perioan Indian		
1215-0036 within 72 hours after death with the Maryland ene. then 'natural', or Iteme 23e or 28e-f show the Modical Exercites rount be notified at	þ	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces?  1  Yes 2  If Yes, Give Year or Dates:		l I	Was Deceder fYes, specify I□Yes 25		Mexican, Specify:	Puerto Ricar	n, etc.)	Black, Wh	ite, etc.		
5-0 72 ho	eted	15. Decedent's Edu (Specify only highest grad			16a. Deced	lent's Usual (	Occupation	on ing most c	of working	16	b. Kind of Busines:	s/Industry		
2121 ad within /giene. er then	Completed	Elementary/Secondary (0-12)	College (1-4or 5	+)	Forem	kind of work DO NOT use I <b>an</b>	retired)	ing most c	or working		BGE	BGE		
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Depertment of Heelth and Mental Hygiene. Important: If tem 27 is marked other then "natural", or iteme 23a or 28a-1 show any injury or other treumetic event, the Medical Examinar must be notified at once.	To Be	17. Father's Name (First, Middle, Last) William Pinder					18		s Name <i>(Fir</i> s		iden Sumame)			
Mar nd 2 sh lith and 17 16 m		19a. Informant's Name/Relationship (Ty Evelyn Pinder/ Wit								e, MD 2	ity or Town, State,	Zip Code)		
s 1 ar s 1 ar s Hee s Hee s Hee other		20a. Method of Disposition		20b. Pla	ce of Dispos	sition (Name natory or othe	of	1	Date		c. Location - City or	r Town, State		
Pages nent of Pages ant: If Ite		1  Burial 2  Cremation 3  F 4 Donation 5 Other (Specify)						em.03	/15/20	006 Ba	ltimore,	MD		
Baft  permit. Depertr Imports any inji		21. Signature of Funeral Service Licensee Kimberly Davidson  Leonard J. Ruck, Inc. Baltimore, M										Rd. 21214		
B760, Tate be executed  We dical Examiner  This burial-transit  The burial-transit  Th	Examiner	23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, flary Jodoing to firm ediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a	a conseque	ence of):	A L			ardiac or resp	oiratory arrest		Approximate Interval Betwood Onset and D	veen	
the state of the s	dlcal		1.		-									
death certi	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome 1□Live birth 4□Pregnant at 9□Unknown	2 🗌 Fetal d	leath 3□	Ectopic pregi Other (s <i>peci</i>					23d. Date of de Month		'ear	
ecords, P.O. I law requires that the de es been signed by the a 2 should be detached i	Þ	Part II. Other significant conditions con	tributing to death bu	it not result	ing in the un	derlying caus	se given i	n Part I.	2	23e. Did tobac	co use contribute to	o the cause of de		
VITAI KECORDS, iiclan: The law requires t certificate hes been signe rector, page 2 should be or	Completed		a selen	0	nell	140			2	4a. Was an	24b. Were a	utopsy findings a	vailable	
The The ate h	Com		1000						_	autopsy performed ☐ Yes 2 ☑	prior to death?	completion of ca	use of	
Of VITAL IP Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	lospital:					6. Place of	Death (Che	ick only one)				
Phys r this	); To	1 Yes 2 No	1 🗀 Inpatier		R/Outpatient 8b. Time of		Other:				e 6 □Other (Spe	cify)		
VISION OI Attending Phrindeath. ector: After thi by the funeral	ation	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injur (Month, Day	Year)	Injury	м	Injury at Work?	2 □ No		ASCIDE NOW	njury occurred			
DIVISION al or Attending s after death. II Director: Atte d in by the fune	ertification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inju building, etc	ry - At hom . (Specify)	e, farm, stre	et, factory, o	ffice		28f. L	ocation (Stree ity or Town, S	t and Number or Ri tate)	ural Route Numb	19 <i>r</i> ,	
DIVISIO  To the Hospital or Attendi within 24 hours afler death.  To the Funeral Director: A completely filled in by the tu	edical C	29a. Certifier (Check only one) 1 Certifying Phys	sician: To the best of her: On the basis of and manner star	examinatio	edge, death n and/or inv	occurred at t estigation, in	he time, my opini	date and pon, death	olace, and do occurred at t	ue to the caus the time, date	e(s) and manner as and place, and due	s stated. s to the cause(s)		
To the within To the comp	Me	29b. Signature and title of certifier	Ma	_		29c. L	icense nu	umber	· ~	29d.	Date signed (Mont	h, Day, Year)		
./		<b>P</b>	you	4)	(G)		#3	55	93		3/13/	08		
5		30. Name and address of person who co	1 1	ath (Item 2	23a) (Type, P	Print)	no	( )	Ave	Balo	6.; M	0.21	27.1	
Sta Registr		31. Date filed (Month, Day, Year)	32. Registra	r's Signatur	6004	4		- \ /	V				+	

			<b>1 - For</b> Stata Registrar <b>Amend Item</b>	State of Marylan  F29d&30 PER P						giene Reg. No	4000	07561
	Physici	an	1. Decedent's Name (First, Middle, Last)	) \ .			,	<b></b>	2. Date of De Month	Da		3. Time of Death 2:50 PM
	/Medio		4a. Facility Name (If not institution, give s			4b. City	, Town, or	Location of Deat		40	. County of Death	
			Suburban Hospi 5. Social Security Number 6. Sex		last birthday		nesd er 1 Year	ov. If Under 24 Hrs.	8. Date of Bir		nontgon	place (State or Foreign
	Funeral Director		369-22-2302 15	M 200 F	Yrs.	Months	Days	Hours Min.	2-6-1	y, Year,	COL	higan
land	Mo W		Usual Residence of Decedent  10a. State 10b. County	10c. Cit	y, Town or Lo	ocation						10d. Inside City Limits
e Man	8a-1 en	ctor	mo montgon	nery Be	thes							1 ☐ Yes 2 🛣 No
with th	Se or 2	Dire	8815 Earl Cour	+		101. Z	ip Code	П		10g. Ci	itizen of What Cou SA	intry?
r death	er mus	Funeral Director		12. Was Decedent Ever in U Armed Forces?	.S. 13.	Was Dec	edent of His	spanic Origin? (S n, Mexican, Puert	pecify Yes or No o Rican, etc.)		14. Race - Ameri Black, White	
d 21215-0036 filed within 72 hours after death with the Marvland	i', or i	<u>ام</u>	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ☐ Yes 2 M No If Yes, Give Year or Dates:		1 🗆 Yes	2 No	Specify:			Specify: B	ack
5-0 22 Po	oleal E	Completed	15. Decedent's Educ (Specify only highest grade		(Give	kind of w	ual Occupa ork done d	uring most of wor	rking	16b. k	(ind of Business/Ir	ndustry
Maryland 21215-0036	r than	dwo	Elementary/Secondary (0-12)	Cotlege (1-4or 5+)	Civi	/	use retired)	1		Gr	overnmen	et
	Department of Heelth and Mental Hygiene. Important: If item 23a or 28a-1 ehow any injury or other traumatic event, the Medical Examiner must be notified at once.	Be	17. Father's Name (First, Middle, Last)					18. Mother's Nar				
aryk should	nd Mer mark umatic	ဍ	19a. Informant's Name/Relationship (Ty)		19b. Maili	ng Addre:		COYNE			or Town, State, Zi	p Code)
3, M	m 27 ls		Segun Adebayo/so					bethesdo	MD2		_	
Baltimore,	ant of H		20a. Method of Disposition  1 ☐ Burial 2 ☑ Cremation 3 ☐ R  4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	Place of Dispo cemetery, cre 250Peo	matory or	other place	. // (	1-06		ocation - City or T HSVILLE I	
	spartme sportar sy injur		21. Signature of Funeral Service License	90	2:	2. Name a	and Addres	s of Facility Ray	pFwen	ala	nd Crema	tion Services
	10 E E a	-	23a. Part1. Enter the disease, or compli	mol35							1D 2091	Approximate
Pi	nysician		shock, or heart failure. List only on Immediate Cause (Finat disease or condition	e cause on each line.  Myocardial					,	,	0	Interval Between Onset and Death
	/Medical xaminer		resulting in death)	Due to (or as a conseq								
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a conseq	uence of):							
xecuted	and I-transi	Examin	Cause (Disease or injury that initiated events resulting in death) Last	. Due to (or as a conseq	uence of):							
8760, cate be executed	physicien and s the burial-transit	dicai E	L.									
	ding ph	/Medi	IF FEMALE:	3c. If yes, outcome of pregna	anov.							
Box 6	ed by the attending detached for use at	Physician/Me	23b. Was decedent pregnant in the past 12 months?  1 \( \subseteq Yes \) 2 \( \overline{\overlin	1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d	I death 3	⊒Ectopic ⊒ Other (s	pregnancy specify)				23d. Date of deliv Month	ery Day Year
P.O.	ed by th detache	Phys	9 ☐ Unknown  Part II. Other significant conditions con	9☐ Unknown	ulting in the u	underh <sub>i</sub> ina	Cause dive	n in Part I	23a Didt	obacco	use contribute to	the cause of death?
I Records, P.O The law requires that the	n signe	d by	Diabetes Mellitus		alting in the c	indenying	cause give	THE FACT.		Yes 2		bably 4 Unknown
eco aw re	hes been s	Completed	Hypertension						24a. Was	psy	prior to co	opsy findings available omptetion of cause of
Vital Records, sician: The law requires t	ificate to		25. Was case referred to medical					OC Plans of Day	perion 1 ☐ Yes	2 No	death? 1 ☐ Yes	2 No
of Vi	his cert I direct	To Be	eyaminer?	ospital: 1 Inpatient 2	ER/Outpatie	nt 3 🗆 E	Othe				6 ☐Other (Speci	fy)
Division of	h. After t funera	tion:	27. Manner of Death  1   Natural 5 □ Pending 2 □ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	of M	28c. Injury Work 1 ☐ Y	at ? ′es 2 ⊡No	28d. Describe	how inju	iry occurred	
IVISI TAtten	irector irector by the	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At he building, etc. (Specif	ome, farm, st	reet, facto	ory, office		28f. Location ( City or To	Street a	nd Number or Rur e)	al Route Number,
Division of Vita	within 24 hours after death. To the Funerel Director: After this certificate he completely filled in by the funeral director, page		29a. Certifier 1☐ Certifying Phys	sician: To the best of my kno		h occurre	d at the tim	e, date and place				stated.
the Ho	the Full	Medical	(Check only 2 Medical Examir one)	ner: On the basis of examina and manner stated.	ition and/or in	vestigatio	n, in my op	inion, death occu	irred at the time,	date an	d place, and due	to the cause(s)
١	To To	2	29b. Signature and Itle of contriber			2	9c. License				ate signed <i>(Month,</i>	Dey, Year)
			30. Name and odress of person who co			-		01302		-	2,2000	
			Atul Rohatgi, M.D., S 31. Date filed (Month, Day, Year)	Suburban Hosi	tal, B	ethe:	sda, M	D				
	Sta Registr		MAR 1 3 200	32. Registrar's Signa	F ASS	Park Comment	22					

Lenora Hutchins Pate Baltimore, Maryland 21215-0036

			Please T	ype or Print in				•	•	ble.	
			1 - For State Registrar	State of Maryla		rtificate of		-	Reg. No.	6 (	)7562
	Physici /Medic	_	1. Decedent's Name (First, Middle, Last)  Lenora H. Pate					2. Date of De Month	4 2, 2	Year OOG	3. Time of Death 0950 AM
	Examin	- 3	4a. Facility Name (If not institution, give s  Sina': Hos Pi  5. Social Security Number 6. Sex	tal of Bu	Himore rs. last birthday)	4b. City, Town, o	r Location of Death TWOVE If Under 24 Hrs.	8. Date of Bir	4c. County		place (State or Foreign
2855	Funeral Director			M 2₹F 6:		Months Days	Hours Min.	(Month, Da	y, Year) 5, 1944	Cour	yland
	e Marylan la-f show	ctor	MD 10a. State 10b. County	10c.	City, Town or Lo					1	0d. Inside City Limits
	n with th	ai Dire	10e. Street and Number 3915 Callaway Aven	ue #701		10f. Zip Code	215		10g. Citizen of USA	What Cour	itry?
036	n 72 hours atter death with the Maryland "natural", or Itema 23a or 28a-f show salcal Examinar must be notified at	by Funeral Director	11. Marital Status  1 □ Never Married 2 □ Married  3 □ Widowed 4 ☒ Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		1	lispanic Origin? (Sp an, Mexican, Puerto Specify:	ecrfy Yes or No Rican, etc.)		ce - Americ ck, White,	
21215-0036	within ene. then *	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12) 12	cation e completed) College (1-4or 5+)	(Give	dent's Usual Occup kind of work done DO NOT use retired retary	durina most of work	ing	16b. Kind of B	usiness/in	<sup>dustry</sup> unk
pu	be tiled tat Hygid d other event, I	Bec	17. Father's Name (First, Middle, Last)				18. Mother's Name			пө)	
Maryland	Mer Mer arks	မှ	Frank W. Hutchins		10h Maili	on Address /Stroot	Bernice and Number or Run			State 7is	Codol
Ma	d 2 : 7 is 7 is trau		19a. Informant's Name/Relationship (Ty. Sandra Taylor/da			-	and Number of Auto oad Baltin			_	Code)
Baltimore,	Pages 1 and 3 nent of Health ent: If Item 27 ury or other tr		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ R 4 ☑ Donation 5 □ Other (Specify)		p. Place of Dispo cemetery, crei	osition (Name of matory or other plai		Date	20c. Location	- City or To	own, State
Balt	permit. Pag Department Importent: I eny injury o		21. Signature of Funeral Servic License Ronald S V	ade Direct	or St	2.Name and Addre tate Anat altimore,	omy Board		Baltim	ore S	treet
6.	Physician /Medical Examiner		23a. Part   Enter the disease, or combination or heart failure/ List only or Immediate Cause (Final disease or condition resulting in death)	catters that caused the die cause on each line.  Due to (or as a constitution)					rrest,		Approximate Interval Between Onset and Death Adden
68760,	death certificate be executed eattending physician and id for use es the burial-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a cons							0:
O. Box	at the death certif by the attending tached for use ex	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 → No 9 □ Unknown	3c. If yes, outcome of pre 1 Live birth 2 F 4 Pregnant at time of 9 Unknown	etal death 3	□Ectopic pregnanc □ Other (specify) _	y			ate of delive onth	ery Day Year
rds, P.	signed be de	þ	Part II. Other significant conditions cor	ntributing to death but not	resulting in the u	inderlying cause giv	ven in Part I.				he cause of death? pably 4 Unknown
Vital Records,		Completed						24a. Was auto perfo 1 \( \text{Yes}	psy ormed!	Were auto prior to co death? 1 \( \text{Yes}	opsy findings available impletion of cause of
Vita	Physicien: Th this certificete ral director, pag	Be	25. Was case referred to medical exampler?	lospital:	+/	ot 20 pos Ott	26. Place of Deat				
n of	ding Phys h. Atter this funeral di	on: To	27. Manner of Death  1 Pratural 5 Pending	1 ☐ Inpatient 2  28a. Date of Injury (Month, Day Year	28b. Time o	III 3LI DOA	4   Nursing no		dence 6 Otto		у)
Division	or Atten frer deat Sirector: in by the	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - A building, etc. (Sp.	it home, farm, st		Yes 2 □ No	28f. Location ( City or To		ber or Run	al Route Number,
	To the Hospitel or Atten within 24 hours after deat To the Funerel Director: completely tilled in by the	Medical Ce	29a. Certifier 1 Certifying Physician (Check only one) 2 Medical Exami	sician: To the best of my ner: On the basis of exam and manner stated.	knowledge, deat	th occurred at the till evestigation, in my o	me, date and place, opinion, death occur	and due to the red at the time,	cause(s) and m date and place,	anner as s , and due t	itated. o the cause(s)
)	To th within To th compl	Me	29b. Signature and title of certifier	Alomo	~ MI	29c. Licens		2	29d. Date signe	-	
			30. Name and address of person who co	ompleted cause of death (	Item 23a) (Type,	Print) P3P (F	reese	100 E	3 3	But	2006 tomme
	Sta Registi		31. Date filed (Month, Day, Year)  MAD 1 3 2	32. Registrar's Si		Carles	-/.	,		~~ 0	, , , , ,

31. Date filed (Month, Day, Year)
MAR 1 3 2006

Course

		For State Registrar	State of Marylan			of Health and of Death	d Menta	l Hygier	2000	075	63
Physici /Medio Examir	al	1. Decedent's Name (First, Middle, L BALKKLL ANN 4a. Facility Name (If not institution, gi	RUSE ive street and number)		4b. City, To	own, or Location of De	Mo	MARCH	Pay Yell 6 , 20	26 11:4 eath	4@F M
Funeral Director		213 64 6861	Medical Cen Sex 10M 207 7. Age (In yrs. 4/6		If Under 1 Months (	Year If Under 24 H	in. (Mo	te of Birth onth, Day, Yea	9.	ltimore Birthplace (State Country) M.D	
e Maryland 3a-f ehow	ctor	Usual Residence of Decedent  10a. State 10b. County  M.D. N	,	y, Town or L BAILIM	one			,		10d. Inside (	City Limits
death with the 23e or 28	Funeral Director	10e. Street and Number  1814 H1PE ##  11. Marital Status	12. Was Decedent Ever in U	.S. 13.		ode  202  nt of Hispanic Origin? Cuban, Mexican, Pu	(Specify Ye			merican Indian,	
within 72 hours after death with the Maryland ene. than "natural", or iteme 23e or 28e-f show he Medical Examiner must be notified at	by	1 Never Married 2 Married 3 Widdwed 4 Divorced	Armed Forces?  1 Tyes 2 December 1 Tyes, Give Year or Dates:		1 Yes, specify 1 Yes 2	<b>≩No</b> Specify:	ierto Hican,			thite, etc.	
gos 1 and 2 should be filed within 72 hours after death with the Marylar it of Heelth and Mental Hygiene. If item 27 is marked other than "natural", or iteme 23e or 28a-f ehow or other traumatic event, the Madical Examinar must be notified at	Completed	(Specify only highest g Elementary/Secondary (0-12)	College (1-4or 5+)	(Give	kind of work DO NOT use	done during most of retired)			19/as 7	ranspukto	from
should be fi and Mental H s marked ot umatic ever	To Be	17. Father's Name (First, Middle, Las   Hornes GEE   19a. Informant's Name/Relationship		19b. Mail	ing Address (S	Saka.	Thor	mpsist		'e, Zip Code)	
Pages 1 and 2 nent of Heelth a int: if item 27 to		7 Exesta Russe-U 20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spec	DRomoval from State		matory or oth	And ess of Facility					
permit. Pag Department Important: eny injury o		21. Signature of Funeral Service Lic	etto	j	129 N.	Caroline st	301+	more MD		Approxim	ato
Physician // Medical Examiner prize	icai Examiner	shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to limmediate cause. Enter Underlying Cause (Disease or injury that indiated events resulting in death) Last	a. SEPSIS  Due to (or as a consect  b. ASPIRATIO  Due to (or as a consect  c. Due to (or as a consect  d.	N FNE	UMONI	А				Interval B Onset and	1 Death
death certifica e ettending ph od for use as ti	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 D No 9 ☐ Unknown	23c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of o	al death 3	□Ectopic pre∢ □ Other (spec				23d. Date of Month	delivery Day	Year
sign d be	by	Part II. Other significant conditions	contributing to death but not res	sulting in the	underlying cau	se given in Part I.	2:	3e. Did tobacc	_	te to the cause o	f death?
	Completed						-	4a. Was an autopsy performed Yes 2	3 deal		s availab cause of
Physicien: Tribis certificetral director, pr	Be	25. Was case referred to medical examiner?  1 Yes 2 No	Hospital: 1 Inpatient 2	3500000		Other:			S (1104)	C 6-1	
ing After une	ation: To	27. Manner of Death Natural 5 Pending 2 Accident investigat	28a. Date of Injury (Month, Day Year)	28b. Time Injury		c. Injury at Work? 1   Yes 2   No			6 Other (	<i>Эреспу)</i>	
- 9	Certification;	3 Suicide 6 Could not determine	building, etc. (Speci	ify) 			C	ity or Town, St	ate)	r Rural Route Ni	ımber,
To the Hospitel c within 24 hours of To the Funeral D completely filled in	Medical	(Check only 2 Medical Ex	Physician: To the best of my kn aminer: On the basis of examin- and manner stated.	owledge, dea ation and/or i	nvestigation, i	the time, date and pin my opinion, death o	lace, and du occurred at t	he time, date	and place, and	due to the cause	
	-	29b. Signature and fittle of certifier	li	- 02-1 (**	I	) 4635Ø		Mi	arch	B, 20	
3 St. Regist	ate	30. Name/and addless of person what KHOSROW TABAS  31. Date filed (Month, Day, Year)	32. Registrar's Sign	L OSL	ER DRI	IVE TOWS	ON MA	RYLAN	D SISA	3 4 <sub>1</sub>	

State of Maryland / Department of Health and Mental Hygiene 07564 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death MARCH 8, 2006 Year **Physician** ROTHMAN Рм SYLVAN 5:36 /Medical 4c. County of Oeath 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** SLADE MANSION ASSISTED LIVING BALTIMORE BALTIMORE | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | MAR 9, 1911 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days 1 M 2 □ F 94 Yrs. 215-09-9837 Director Usual Residence of Decedent the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other treumetic svent, the Madical Examinat must be notified at once. 10a. State 10b. Count 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Director BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7503 PARK HEIGHTS AVENUE 21208 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced 16.
Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) **PROPRIETOR** GROCERY STORE 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) ROTHMAN PAULINE (UNKNOWN) SAMUEL 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 109 N. BRIDGE STREET - ELKTON, MD 21921 STEPHEN ZISKIND / NEPHEW 20b. Place of Disposition (Name of cometery, crematory or other place) ZION 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State LIBERTY PARK SHAAREI | 03/10/2006 RANDALLSTOWN, MD ^ 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licensee 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Priysician Ischemic Cardiomyopathy /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 attending physician Physician/Medical as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 Other (specify) ed by the a detached f 9 Linknown 9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Donknown Dementia Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed 2 No I or Attending Physician: after death. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Assisted 1 ☐ Yes 2 ☑ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Director: After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 🗀 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide To the Hospital within 24 hours a To the Funeral C 1 🖰 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier cal (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number Koun L. Balrit, M.D DOD 58676 March 9,2000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Karen L. Babitt 25 Main Street, Suite 200, Reisters pown MD 21735 MIP. 31. Date filed (Month, Day, Year) 32. Megistrar's Signature MAR 1 3 2006 Distance. Registrar

		ļ	Please T Amend item#19a,per 1 - For State Registrar	ype or Print in E FH_0353_3/13/06 State of Marylan		<b>delible Ink.</b> artment of He <i>rtificate of D</i>		copies Ar ntal Hygier	as the total total	07565
	Physici /Medic		Decedent's Name (First, Middle, Last)     SYLVIA	LEE		RUBIN	2.	Date of Death Month	Day Year 7	MAN. COLUMN
	Examin Funeral Director		4a. Facility Name (If not institution, give s  SINGI HOSPITAL  5. Social Security Number  213-14-4620  6. Sex	of Baltimo			ore City	Date of Birth (Month, Day, Ye	4c. County of De	ath N/A  irthplace (State or Foreign Sountry) MD
	Aaryland f show ed at	or	Usual Residence of Decedent  10a. State 10b. County  MD BALTIN		y, Town or Lo	ocation I MORE				10d. Inside City Limits 1 ☐ Yes 2 🔯 No
	h with the ? 23a or 28a-	Funeral Director	10e. Street and Number  2 POMONA EAST #306		D1121	10f. Zip Code	21208	10g.	Citizen of What (	Country?
036	be filed within 72 hours after death with the Maryland at Hygiene.  d at Hygiene.  d other than "patural", or items 23a or 28a-f show went, I'm Medical Examinar must be notified at event, I'm Medical Examinar must be notified at	þ	11. Marital Status  1 Never Married 2 Married  3 Nidowed 4 Divorced	2. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates:		Was Decedent of Hisp If Yes, specify Cuban, 1 ☐ Yes 2 X No	panic Origin? (Specify Mexican, Puerto Rica Specify:	Yes or No- an, etc.)	14. Race - An Black, Wh Specify:	nerican Indian, nite, etc. WHITE
21215-0036	within ene. than	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	cation completed) College (1-4or 5+)	(Give	dent's Usual Occupati kind of work done du DO NOT use retired) MAKER	on ring most of working		Kind of Busines	s/Industry
Maryland 2	2 should be filed with and Mental Hygiene is marked other tha aumatic event, the	To Be Co	17. Father's Name (First, Middle, Last) LOUIS		SCHL	OSSBERG	8. Mother's Name (F	irst, Middle, Maid		ILVERMAN
	12 E		19a. Informant's Nama/Relationship (TV) LEGN LOUIS RUBIN / HUSI LEON RUBIN / SON	pe, Print) <b>and</b>		ng Address (Street an MONA EAST			ity or Town, State MD 2120	
altimore,	Page nent c ant: if ury or		20a. Method of Disposition  1   Burial 2 □ Cremation 3 □ R  4 □ Donation 5 □ Other (Specify)	emoval from State	emetery, cre H EL M	osition (Name of matory or other place) EMORIAL PA	NRK 03/09/2	2006		_STOWN, MD
Ba	permit. Pa Departmen Important any injury once.		21. Signature of Funeral Service License	Z	8	2. Name and Address 900 REISTE	RSTOWN RO	AD - PIK	I & BROS (ESVILLE	, MD 21208
60,	Physician /Medical Examiner pruse; transit	al Examiner	23a. Part1. Enter the disease, or complishook, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	e cause on each line.	UCCLY (quence of):	dial Independent	farction	spiratory arrest,		Approximate Interval Between Onset and Death ONE WEEK
. Box 687	ath certificate ittending phys or use as the	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 Ū No 9 □ Unknown	3c. If yes, outcome of pregni 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of d 9 □ Unknown	ıl death 3[	□Ectopic pregnancy □ Other (specify)			23d. Date of o	lelivery Day Year
rds, P.O	quires that the de in signed by the a uld be detached f	þ	Part II. Other significant conditions con Encl Stage Renal					23e. Did tobace		to the cause of death?  Probably 4 □Unknown
Hecords,	The law requirate has been size to bage 2 should	Completed	Chronic Obstruction	e Pulmonary	Dise	ase		24a. Was an autopsy performed	prior t	
of Vital	1   Yes 2   No   No   No   Yes 2   No   No   No   No   No   No   No									pecify)
Division	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Certification:	27. Manner of Death  1 ( Natural	28a. Date of Injury (Month, Day Year)  28e. Place of Injury - At h building, etc. (Speci.	28b. Time of Injury ome, farm, st	Work? M 1 □ Ye	es 2 No	Location (Stree City or Town, S	t and Number or	Rural Route Number,
	ne Hospita ne Funera bletely fille	edical C	29a. Certifier 1D Certifying Physical (Check only one) 2 Medical Examin	rician: To the best of my knoner: On the basis of examination and manner stated.	owledge deal	th oncurred at the time evestigation, in my opi	i date and place, and nion, death occurred	due to the caus at the time, date	o(t) and marrier and place, and d	25 stated ue to the cause(s)
	To the within to the comp	Me	29b. Signature and title of certifier  **Dues Symmotory**	aLDO	S-18		number		Date signed (Mo	nth, Day, Year) - , 2006
1	' '		Eileen S. ZM	mpleted cause of death (Iter 9mcn D.O. 39Registrar's Signa	SIM	ai Hospit	al of Bal	Himore	2	
	- Sta		MAR 1 3 200	6	a for	ache s				

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Frank Gabriel St. Leger 2006 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Bal timore Sti Agnes Healthcane Social Security Number If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Hours 1**X** M 2□ F 72 218-28-6637 Yrs May 8, 1933 Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Maryland Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21228 United States 709 Maiden Choice Lane Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black. White, etc. 1 ☐ Yes 2 ZÑNo If Yes, Give Year or Dates: 1 Never Married 2 Married White 1 ☐ Yes 2XNo Specify: Specify 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Decupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Parks & Recreation Grounds keeper 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Bayview Crematory

Dreumonia

3 Ectopic pregnancy

28c. Injury at Work?

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

1 ☐ Yes 2 ☐ No

19511

5 Other (specify)

Celluli +13

2 ER/Outpatient 3 DOA

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

23a. Part 1. Emer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Aspiration

Due to (or as a consequence of)

Due to (ar as a consequence of)

Due to (or as a consequence of)

2 | Fetal death

23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Intarction

1 Inpatient

MD

900

32 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2006

9 Unknown

4 Pregnant at time of death

Mary Margaret Sweitzer

22. Name and Address of Facility Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229

20c. Location - City or Town, State

23d. Date of delivery

Day

3 Probably 4 Unknown

24b. Were autopsy findings available prior to completion of cause of death?

2 X No

Month

23e. Did tobacco use contribute to the cause of death?

1 Tyes

2 X No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

1 ☐ Yes

28d. Describe how injury occurred

24a. Was an autopsy perform

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

1 Yes 2 🔽

26. Place of Death Check only

Avenue, Baltimore MD 2122

Baltimore, Maryland

2 days

Year

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2803 Page Court, Fallston, Maryland 21047

3/13/06

**Physician** /Medical Examiner

permit. Page Department of Important: If eny injury or once.

**Physician** 

/Medical

Examiner

10a. State

**Funeral** 

Director

or itema 23a or 28a-f show

"natural".

then '

other

Pages 1 and 2 should be fil ment of Health and Mental H tant: If Itam 27 is marked ott jury or other traumatic even

filed within 72 hours after death

Baltimore, Maryland 21215-0036

the Mudical Examiner must be notified at

Director

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Completed

Be

Examiner

Be Completed by Physician/Medical

Certification; To

Medicai

State

the funeral director.

Director:

within 24 hours a To the Funeral D

James Michael St. Leger 19a. Informant's Name/Relationship (Type, Print)

20a. Method of Disposition

Immediate Cause (Final disease or condition resulting in death)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

23b. Was decedent pregnant

9 Unknown

in the past 12 months? 1 ☐ Yes 2 ☐ No

Seizure

Lett

1 Yes 2 XNo

27. Manner of eath

1 Natural Accident

3 Suicide

29a. Certifier

4 Homicide

ZHU

31. Date filed (Month AR

25. Was case referred to medical examiner?

29b. Signature and title of certifier

ZHU, Zeyin

Zegin

Myocardial

Cower

investigation

6 Could not be determined

5 Pending

IF FEMALE:

21. Signature of Funeral Service Licensee

Eleanor Mary Michalov / Sister

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Decation 5 ☐ Other (Specify)

or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

> Registrar DHMH 17 Rev 1/2001

Ms

Caton

Pleas	se Type of Print in Black Indelible ink. Ensure /	All Copies A	are Le	egible.	
,	State of Maryland / Department of Health and	Mental Hygi	iene	300	0-15-6-
ite gistrar	State of Maryland / Department of Health and  Certificate of Death	Re	g. No:	106	0/56/
dent's Name (First, Middle,	Last)	Month	1		3. Time of Death
seph Earl S	Schlick	March	4,	2006	4:58 P

Physician /Medical Examir

Funeral Director

permit. Pages 1 end 2 should be filed within 72 hours after deeth with the Maryland Depertment of Health and Mental Hygiene. Important: if item 27 is marked other than "naturel", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examinar must be notified at once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospitel or Attending Physicien: The law requires that the death certificate be executed within 24 hours effer death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760,

odical Joseph Earl Schlick March 4, 2006											4:58 P	IVI			
min		4a. Facility Name (If not institution, gir University Hospi		nber)		1	Town, or 1 <b>ti</b> m	Location of	of Death		40	n/a	of Death		
ral or			Sex 1⊠M 2□F	7. Age (In yrs. I	ast birthday) 25 Yrs.	II Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da April	iy, Year	980	Cour	place (Stete or Fo htry) yland	oreign
		Usual Residence of Decedent													
		10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits													imits
	Director	Maryland n/a Baltimore												1X Yes 2	No
	rec	10e. Street and Number				10f. Zip	Code				10g. C	itizen of V	What Cour	ntry?	
	0	1702 Spence Stre	et.			2	1230				United States				
	Funerai	11. Marital Status		dent Ever in U.	S. 13.										
	ä	1 X Never Married 2 ☐ Married	Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)						14. Race - American Indian, Black, White, etc.						
	<u>۾</u>	3 ☐ Widowed 4 ☐ Divorced	1 Tes If Yes, Giv Year or Da	e ates:		1 🗆 Yes	2 🔀 No	Specity:				Specify	.Whit	æ	
	Completed	15. Decedent's E	Education		16a. Dece	dent's Usua	al Occupa	ation			16b. F	Kind of Bu	usiness/Inc	dustry	
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	To 8	Christopher Schl	ick					Dot	tie	Drury					
		19a. Informant's Name/Relationship	(Type, Print)		19b. Maili	ng Address	(Street a	and Numbe	er or Run	al Route Numb	er, City	or Town,	State, Zip	Code)	
		Christopher Schl	.ick – fa	ther	1702	Spen	ce S	treet	, Ba	ltimore	e, M	aryla	and 2	21230	- 1
		20a. Method of Disposition		20b. P	lace of Dispo emetery, crea	osition (Nar	ne of	0		Date	20c. L	ocation -	City or To	own, State	
		1 ☑ Burial 2 ☐ Cremation 3 [ 4 ☐ Donation 5 ☐ Other (Spec		סומוט	est Lav					h 8,	Mar	riot	tsvi 1	le, MD	
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er		Due to (or as a consequence of):													
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	ysic	t ☐ Yes 2 ☐ No 9 ☐ Unknown	9☐ Unkno		ain 5L	Other (sp	ecity)								
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-	ati	2 Accident investigation		106	123	3 M	10	Yes 2	No	Subi	وع	181	~sY		
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	Medical Certification:	one)	and manr	er stated.											
	2	29b. Signature and title of certifier	0	$\wedge$				number			29d. Da	ate signe	d (Month,	Dey, Year)	
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Registrar

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Funera	ıl	5. Social Security Number 6. Sex	7. Age (In yrs. las	st birthday)	If Under 1 Months	Year II Under Days Hours	er 24 Hrs. Min.	8. Date of Birth (Month, Day, 03/10	Year)	9. Birthp Cour	lace (State or Foreign	
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C = W F		20a. Method of Disposition	20b. Pla	ce of Disposi	ition (Nam	e of			20c. Location			-
O 60 0		14 Burial 2 □ Cremation 3 □ Re 4 □ Donation 5 □ Other (Specify)	imoval from State ARB	UTUS	MEM.	PARK	3/14	/06	BALTI	MOR	E CO., MI	)
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BOX 68/6U,  asth certificate be executed ettending physicien and for use as the burial-transit	edicai E	d										
rdifficating physical		IF FEMALE:				-18						
death certif death certif e ettending id for use a	lan/	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregnand 1 ☐ Live birth 2 ☐ Fetal of 4 ☐ Pregnant at time of dea	death 3⊟6	Ectopic pre					te al delivi inth	ery Day Year	
. 0 00	Physician/M	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown	atin 5 🗆	Other (spe	<i>9019)</i>			, il			
- 2 pg	by PI	Part II. Other significant conditions con		ting in the und	derlying ca	ause given in Pa	rt I.				he cause of death?	
cord	eted		homa								oably 4 □Unknown	4
Records, the law requires te has been signe	Completed	IDDM						24a. Was a autop: perfor	med2	prior to co death?	ppsy findings available impletion of cause of	
Vital Rec licien: The law certificate has l	O	25. Was case referred to medical				26. Pla	ace of Deat	1 ☐ Yes h (Check only or		1 🗆 Yes	2∐ No	
DIVISION Of VITAL or Attending Physicien: 1 after death. Director: After this certificat d in by the funeral director, p	To B	1 105 2 140	ospital: 1 ☐ Inpatient 2 ☐ E					me 5 Resid			n hospice	
OD O	tion:	27. Manner of Death  1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	M 2	8c. Injury at Work? 1 ☐ Yes 2		28d. Describe h	ow injury occur	red	V	
Division or Attendated after death I Director: A din by the f	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - At hon building, etc. (Specify)	ne, farm, stre				28f. Location (S City or Tow		oer or Rura	al Route Number,	-
Utel or urs afte ral Dir												_
DIVISION Of VITAI To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: Atter this certifics completely filled in by the funeral director.	Medicai		sician: To the best of my know ner: On the basis of examination and manner stated.									
To th within To th	Me	29b. Signature and title of certifier	) -			License numbe		i	29d. Date signe	d (Month,	Day, Year)	
1		Holmk	Juni 1	n)		05621			3/8	106		
1	1	30. Name and address of person who co	TIPLE MD 300	23a) (Type, F	Jan	over S	7. 6	Saltin	are, MO	21	225	
Regi	State	31. Date filed (Month, Day, Year) MAR 1-3 2006	32. Registrar Signar	ingested					•			

			For State of M	-	partment of F certificate of			ene . 2006	07569
	q		Decedent's Name (First, Middle, Last)				2. Date of Death		3. Time of Death
н	Physicia /Medic		Martin STEIN				MAR	Day Year	1025AM
	Examin		4a. Facility Name (If not institution, give street and number	)	4b. City, Town, o	Location of Death		4c. County of Death	1
			Howard County Ges	neral Hos	pital C	olumbi	'a	Howa.	od-
	Funeral Director		219-70-9218 ¹™ 2□F	ige (In yrs. last birthd 50 Yrs	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, AUG 1,	Yea <i>r)</i> 9. Birth Con 1955 Ken	nplace (State or Foreign untry) LUCKY
	and w	-	Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or	r Location				10d. Inside City Limits
	sho	ŏ				Baltimore			1 ☐ Yes 2 √No
	28e-1	Director	Maryland Baltimore  10e. Street and Number		10f. Zip Code	рателиоте		g. Citizen of What Co	71
	with ta or		4757 Aldgate Green		101. 24 0000	21227		USA	
	ns 23	Funeral	11. Marital Status 12. Was Deceden	it Ever in U.S.	13. Was Decedent of H		ecify Yes or No-	14. Race - Amer	ncan Indian,
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If Item 27 is marked other then "naturel", or items 23a or 28e-f show eny injury or other treumatic event, the Medical Examiner riust by colling at once.		Amed Forces  1 Never Married 2 Married 1 Yes 2 If Yes, Give  3 Widowed 4 Divorced Year or Dates	XNo .	13. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 X No	an, Mexican, Puerto Specify:	Rican, etc.)	Black, White	o, etc. Vhite
Ö	72 ho	ted	15. Decedent's Education (Specify only highest grade completed)	16a. De	ecedent's Usual Occup	ation	ina 1	6b. Kind of Business/l	Industry
2	thin 7	nple	Elementary/Secondary (0-12) College (1-4or	r 5+)	e. DO NOT use retired	1)		_	
	filed with Hygiene. other ther	Completed by	2	Comp	outer Repai			Computer	Industry
ī	be fill htal H d oth	Be	17. Father's Name (First, Middle, Last)				e (First, Middle, M		
3	should nd Men marke umatic	၉	Charles D. Stein	1 401 41			tricia A		
Maryland	12 sho h and 7 is ma treum		19a. Informant's Name/Relationship (Type, Print)		lailing Address (Street			-	ip Code)
	is 1 and of Health Item 27 other tr		Nicole Stein/Daughter  20a. Method of Disposition		57 Aldgate isposition (Name of crematory or other place			MD ZIZZ/	Town, State
Ö	Pages nent of I ent: If Its ury or o		1 Burial 2 Cremation 3 Removal from State			1		,	
Baltimore,	permit. Pages Department of Importent: If I eny injury or ance.	1	* 4 □ Donation ¯5 □ Other (Specify)  21. Signature		rematory, 22. Name and Addre	The state of the s		Baltimore,	
Ba	permi Depa Impo eny ii	r X	Edward A. Gregorchik		299 Frede	rick Road	<u>Baltimo</u>	Socie <b>ty</b> of re, MD 212	28
П			23a. Part1. Enter the disease, or complications that cause shock, or heart failure. List only one cause on each	ad the death. Do not line.			or respiratory arre	st,	Approximate Interval Between Onset and Death
	Physician	g W	Immediate Cause (Final disease or condition resulting in death)	extic	Shode			//	days
	/Medical Examiner		Due to (or a	s consequence of):					, 1
		-	Sequentially list conditions	unge my					anys
	ted nsit	n lu		- Mariana and a second		for a difference of	m / / m		dun
	cate be executed bhysician and the burial-transit	Examiner	that initiated events resulting in death) Last C. Due to (or a	is a consequence of):	ito bacte	proum	omb		vory,
8760,	cate be ex physician the buria	dicai I	d	Acon	ito bacte	r, Pseu	do won	015	
89		edi							73
Box	death certific e attending p id for use as	Physician/Me	IF FEMALE: 23c. If yes, outcom	ne of pregnancy 2 Fetal death	3 Ectopic pregnancy			23d. Date of deli	very
œ.		icia		at time of death	5 Other (specify)			Month	Day Year
P.O.	at the death by the attern tached for it	hys	9 Unknown						
of Vital Records, I	The law requires that the ate has been signed by thoage 2 should be detache	by	Part II. Other significant conditions contributing to death  Relates Mellity	3	ne underlying cause gr	en in Part I.		acco use contribute to s 2 ☐ No 3 ☐ Pr	the cause of death? obably 4 Dunknown
000	s been s	ompieted	Morhid Obes	ify			24a. Was an		topsy findings available
Ä	The lav			,			autopsy perform 1 Yes 2	led? death?	completion of cause of
ita		Se C	25. Was case referred to medical			26. Place of Dea	th (Check only one	<del></del>	
_f <	d is	ToB	examiner? 1 Yes 2 No Hospital: 1 Inpa	itient 2 ER/Outpa	atient 3 DOA	er: 4 🗆 Nursing H	ome 5 Reside	nce 6 Other (Spec	cify)
n o		1.	27. Manne Death 28a. Date of In (Month, D	njury 28b. Tim Day Year) Inju	ne of 28c. Injur	y at rk?	28d. Describe ho		
Division	r Attsnding er death. rector: After by the fune	ertification;	2 Accident investigation			Yes 2 □ No			
Ξ	l or Attsn after deat Director: i in by the	THE STATE OF	determined 286. Flace of I	Injury - At home, farm etc. <i>(Specify)</i>	, street, factory, office		28f. Location (Str City or Town,	eet and Number or Ru , State)	ıral Route Number,
	urs al	O							
	To the Hospitel or within 24 hours after To the Funerel Direction completely filled in b	edical	29a. Certifier  (Check only one)  1 Certifying Physician: To the best and manner: and manner.	of examination and/	peath occurred at the tipor investigation, in my o	me, date and place opinion, death occu-	and due to the ca red at the time, da	use(s) and manner as ite and place, and due	stated, to the cause(s)
	To t To t	Σ	29b. Signature and the of certifier		29c. Licens			d. Date signed (Monti	
)	1		1 Tanden	mp	V	42897	2	MAR 10	2006
j	[]		30. Name and address of person who completed cause of		/pe, Print)	0-1	10	1- 0	0 200 G nco 1 lumbi 4 210,
~			Francis Chuidian	10724	Little	'a ru x	ent la	ricuray Ce	lum 1214 2104
:-	Sta Regist		A	strar's Signature	Coaste			•	

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Red. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year Month **Physician** Ronald 06 2006 W SCHEUPELE /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Howard 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8 Howard County General 8. Date of Birth Oct. 27, 1939 5. Social Security Number 6. Sex 1₽ M 2□ F 9. Birthplace (State or Foreign **Funeral** Days Months Hours 66 Maryland Yrs 212-36-5162 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28e-fehov event, the Medical Examiner must be notified at 1 Yes 2 No Sussex Selbyville Director 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 29 Bayview West 19975 United States or items 23s Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 72 hours after 1 Never Married 2X Married ☐Yes 2X No Specify: White 1 Yes 2 No Baltimore, Maryland 21215-0036 Specify Yas Give 3 ☐ Widowed 4 ☐ Divorced Year or Dates "naturel". 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within 7; Department of Health and Mental Hygiene. Important: if Item 27 is marked other then "na eny injury or other traumatic event, Ita Madic 2006. Elementary/Secondary (0-12) College (1-4or 5+) 12 6 Attorney Law 18 Mother's Name (First Middle Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Eugene Scheufele Pearl Virginia Cofield 0 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara Scheufele 29 Bayview West, Shelbyville, DE 19975 20b. Place of Disposition (Name of cometery, crematory or other place)
West Arundel
Crematory 20a. Method of Disposition
1 → Burial 2 → Cremation 3 □ Removal from State 20c. Location - City or Town, State 4 □ Donation ☐ □ Other (Specify) 3-10-2006 Odenton, MD Signature of Funeral Service Licensee 22. Name and Address of Facility Ambrose Funeral Home, Inc. 1328 Sulphur Spring Rd., Arbutus, MD Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Myocardial Physician Hours disease or condition resulting in death) /Medical Due to (or as a consequence of Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed and Due to (or as a consequence of) P.O. Box 68760. the attending physicien by Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy ö Day Year 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No detached 9 Unknown 9 Unknown ڄ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. been signed Division of Vital Records, 99 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No muss Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has director, page 2 autopsy performed2 1 ☐ Yes 2 ☐ No 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death | Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this filled in by the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After or Attending 1 Natural 5 Pending investigation 1 Yes 2 No death. 2 Accident 24 hours after deat Funarel Director: 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 1 Contitying Physician: To the best of my knowledge death occurred at the time. Sate and observant due to the causa(a) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier within 24 hor To the Funa completely fi (Check only one) and manner stated. the t 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 0 P42892 Hudias 07 2006 -MO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Little Patuxent Parlaway 10724 (0/mm big, MD21044 Francis Chuidian Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

				ent of Health and Mate of Death	Reg. N	4000	07571
ı	Physici		Decedent's Name (First, Middle, Last)     STUART C. TURNER		2. Date of Death Month	Day Year	3. Time of Death 3: 20 PM
	/Medic Examir		THE UNION MEMORIAL HOSPITAL B	City, Town, or Location of Death SALTIMORE CIT	4	Ic. County of Death	
	Funeral Director		5. Social Security Number 212-22-0881 6. Sex 7. Age (In yrs. last birthday) If Ur Moni	ir) Count	ace (State or Foreign ry) GINIA		
	Maryland	tor	10a. State	CITY		10	d. Inside City Limits
	ter death with the Marylan iteme 23a or 28a-f ehow over must be notified at	al Director	10e. Street and Number 2418 W. ROGERS AVENUE	Zip Code 21209		Citizen of What Count	ry?
900	72 hours after death with the Maryland natural', or iteme 23a or 28a-f ehow dical Examber must be positived at	d by Funeral	1 Never Married 2 X Married 1 X Yes 2 No	ecedent of Hispanic Origin? (Sp. specify Cuban, Mexican, Puerto s 2 XNo Specify:	ecify Yes or No- Rican, etc.)	14. Race · America Black, White, e Specify: BL	
Baltimore, Maryland 21215-0036	id within 72 h giene. er then "natu et the Medical	Completed	Elementary/Secondary (0-12)   College (1-4or 5+)	Usual Occupation If work done during most of work T use retired)  GY/MINISTER	ing E	Kind of Business/Ind INTREPREN ELF-EMPL	EUR
land	uld be file Aental Hy rked oth tic event	To Be (	17. Father's Name (First, Middle, Last)  JOHN ROBERT TURNER		e (First, Middle, Maide AH YOUNG	en Sumame)	
Mary	s 1 and 2 should f Health and Men item 27 ie marke other treumatic	0 18		ress (Street and Number or Run ROGERS AVEN	. ,		
more,	0 0		20a. Method of Disposition  1X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)  20b. Place of Disposition cemetery, crematory MD VETERAL GARRISON I	(Name of	Date 20c.	Location - City or Tov	vn, State
Balti	permit. Pag Department Important: I any njury o		21. Signature of Foneral Service Licensee 22. Nam		WELL FUN		
100	Physician			Approximate Interval Between Onset and Death			
	/Medical Examiner			NEUMONIA	q	5	DAYS
8760,	sate be executed only sicien and the burial-transit	Ical Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):				
P.O. Box 68	death certific le ettending p ed for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown  23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectop 4 Pregnant at time of death 5 Other	ic pregnancy r (specify)		23d. Date of deliver Month	<b>y</b> Day Year
	law requires that the as been signed by th 2 should be detache	þ	Part II. Other significant conditions contributing to death but not resulting in the underlying	ng cause given in Part I.	23e. Did tobacco	use contribute to the	
Division of Vital Records,	The lar	Completed			24a. Was an autopsy performed?	prior to com death?	sy findings available pletion of cause of
Vita	Physician: Th this certificate ral director, pag	To Be	25. Was case referred to medical examiner?  1  Yes 2 No Hospital: Inpatient 2 ER/Outpatient 3	Other	h (Check only one)	6 ClOther /Specify	
ion of	Attending Physic death.  •ctor: After this by the funeral di		27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 28a. Date of Injury (Month, Day Year) 28b. Time of Injury M		28d. Describe how in		
Divis	ai or Attens s after deats al Director: ed in by the	Certification:	3 Suicide 4 Homicide  6 Could not be determined  28e. Place of Injury - At home, farm, street, far building, etc. (Specify)	ctory, office	28f. Location (Street City or Town, Sta		Route Number,
	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director.	edical	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, death occur  Check only one)  Certifying Physician: To the best of my knowledge, death occur  Certifying P	rred at the time, date and place, tion, in my opinion, death occur	and due to the cause red at the time, date a	(s) and manner as sta nd place, and due to	ited. the cause(s)
	To t withi To tl	W	29b. Signature and title of certifier    Complete 9-years   M   D	29c. License number ATR 4 3894		Pate signed (Month, D	Zuo 6
	H			VION MEMOR	LIAL HOS	PITAL,	MD.
	Sta Registi		31. Date filed (Month, Day, Year) 32. Registrar's Signature	di .			

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Year Physician John Earl Till 2006 March 6 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner 11843 St. Martins Neck Rd. Bishopville Worcester If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Jan. 21, 1933 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1⊠M 2□ F Maryland 218-28-7824 73 Yrs. Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits 28e-f show other than "natural", or Itema 23e or 28e-f sho vent, the Medical Examinar must be notified at 1 ☐ Yes % No Directo MD Worcester Bishopville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11843 St. Martins Neck Rd. 21813 Pages 1 and 2 should be filed within 72 hours after deeth by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1XDYes 2 □ No 14/57 Yes, Give 3/19/61 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2√2 No Specify: 3KWidowed 4 ∏ Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Colfege (1-4or 5+) Elementary/Secondary (0-12) Hygiene. Stock Manager Warehouse 7 is marked other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) of Health and Mental Filtem 27 is marked of Martin Peter Till Mary Dorothy Conway 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Paul Till/ Son 11843 St. Martins Neck Rd. Bishopville, MD 21813 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Depertment of H Important: If ite any Injury or ot once. Maryland Veteran Cemetery @ Crownsville 3-10-2006 Crownsville, MD 12⊠Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cemetery 22 Name and Address of Facility Ambrose Funeral Home of Lansdowne 2719 Hammonds Ferry Rd. Lansdowne MD 21227 21. Sgrature of Funeral Serv 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ASCVD /Medical Due to (or as a consequence of): Examiner TN H Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine attending physicien and for use as the burial-transit the Hospitel or Attending Physician: The law requires that the death certificate be executed CHF Due to (or as a consequence of): P.O. Box 68760. Physician/Medical IF FEMALE 23c. ff yes, outcome of pregnancy 1 Live birth 2 ☐ Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 4☐Pregnant at time of death 5 ☐ Other (specify) ete has been signed by the page 2 should be detached 9 🗍 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 1 Yes 2 No 3 Probably 4 ☑ Unknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2□ No 1 Yes 2 100 certificete director 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other 4 Nursing Home 5 Nesidence 6 Other (Specify) 1 Yes 2 No this After this funeral of 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) Certification: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No Director; / 2 Accident investigation 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 24 hours after of Funeral Direct 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 157952 3/6/ 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 106 Milford ST # 504B Salis Bury MD 21804 M.) Babulal Das 32. Registrar's Signature MAR 1.3 2006 > Maluso Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Reath Day th Year b Month Physician TISDALE MARCH WILHELMENIA /Medical Examiner Kandallstown Jorthwes If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) 9. Birthplace Country) **Funeral** Days Months Hours 06-26-9261 1 ☐ M 2 🔽 F Yrs. Director Usual Residence of Decedent 10a. Stale 10b. County 10d. Inside City Limits or items 23a or 28a-f ehow the Medical Examiner must be notified at 1 Yes 2 No **Funeral Director** 10g. Citizen of What Country? 10e. Street and M 10f. Zin Code 2113 Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify þ Specify. 3 ☐ Widowed 4 Divorced "natural". Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 end 2 should be filed within 7. Depentment of Health and Mental Hygiene. Important: if item 27 is marked other then "na eny injury or other treumatic event, the Medic once. Elementary/Secondary (0-12) College (1-4or 5+) cher ets Name (First, Middle, Last) Be 19b. Mailing Ad Town, State, Zip Code) Number, City or 20a. Method of Disposition Burial 2 2 Cremation 3 Removal from State 5 Other (Specify) 21. Sign sure of F 23a. Part1. Enter the disease, or complications that caused the death. Do not enler the mode of dying shock, or heart failure. List only one cause on each line. Approximate Interval Between th as cardiac or respiratory arrest Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** RENAL FAILURE EMOSTAGE /Medical Due to (or as a consequence of) **Examiner** INR V Securitisty in anditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (o) as a consequence of): Examiner After this certificate has been signed by the ettending physician and funeral director, page 2 should be deteched for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Be Completed by Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy Day in the past 12 months? Month Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did l'obacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an Was an autopsy performed?
Yes 21 No 1 Tes 2 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one Hospital: Certification: To 1 ☐ Yes 2 No 1 Inpalient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28b. Time of 28c. Injury al Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 1 Natural 2 Accident s after deam.
rai Director: After 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - Al home, farm, street, factory, office building, etc. (Specify) completely filled in by 4 🗌 Homicide To the Hospitel o within 24 hours af To the Funeral Di 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29b. Signature and title of certifief 29d. Date signed (Month, Day, Year) mella D41410 2006 0 30. Name an add ss of person who completed cause of death (Item 23a) (Type, Print) JOGINDER MEHTA HHPMM MULITURANA MO 32 Registrar's Signature 31. Date filed (Month, Day, Year) State MAR 1.3 2006 Registrar

			1 - For State Registrar	State of Maryland	•	artment of F		, ,	giene leg. No. 006	07574
	Physici /Medic		1. Decedent's Name (First, Middle, Last	Monavar Taher	i			2. Date of Dear Month March	8, Day 2006 Yeer	3. Time of Death 11:00 PM
	Examir Funeral Director		4a. Facility Name (If not institution, give Suburban Hospital 5. Social Security Number 6. Se 227–43–3209		as <i>t birthday)</i> Yrs.		r Location of Death esda If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Oct. 30,	4c. County of Death Montgome 7, Year) 9. Birth Cor	pplace (State or Foreign untry)
	ō	or	Usual Residence of Decedent  10a. State 10b. County  Maryland Montgomer		Town or Lo			500,	1725   112	10d. Inside City Limits 1   Yes 2. No
	ath with the I 23a or 28a- ust be notif	Funeral Director	10e. Street and Number 5915 Ipswich Road			10f. Zip Code 20814			10g. Citizen of What Col Inited State	•
980	hours after death with the Maryland turel; or Iteme 23a or 28e-1 ehow al Examinat roust be notified at	þ	11. Marital Status  1 □ Never Married 2 ☑ Married  3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	1	Was Decedent of H f Yes, specify Cuba 1 ☐ Yes 2X3 No	lispanic Origin? (Spe an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White Specify: Wh	e, etc.
Maryland 21215-0036	be filed within 72 hours after death with the Marylan ital Hygiene. ad other then "naturel", or lieme 23a or 28a-1 show event, the Madical Examiner must be notified at	Completed	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12)	control (1-4 or 5+) College (1-4 or 5+)	(Give life. L	dent's Usual Occup kind of work done DO NOT use retired maker	during most of work	ing	16b. Kind of Business/I  Own Home	ndustry
yland 2	2 should be filed and Mental Hyg ie marked other reumatic event,	To Be C		heri				Ezat S	Maiden Sumame) afari	
	es 1 and 2 should E of Health and Ment fitem 27 ie marked r other treumatic e		19a. Informant's Name/Relationship (T) Dean Zarpak/Son		10805	Lock1and	d Road, Po	otomac,	r, City or Town, State, Z Maryland 20	0854
Baltimore,	permit. Pages 1 Department of H Important: if Ite any injury or ot once.		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify)	Parl	clawn 1	sition (Name of natory or other plac Memorial	Park 200	6 1	Rockville,	Maryland
Bal	Depar Impo		21. Signature of Juneral Service Liochs  23a. Part 1. Enter the disease, or comp	M00877	Ro Ro	Name and Addre	Inc. 300 Maryland	ert A. ) West M   20850-	Pumphrey Funtgomery A	
8760,	Cate be executed hysicien end hysicien end bhysicien end bhysicien end his brutal-transit	dical Examiner	shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a	STIV ence of): AA/ ence of):	IE HEA		AILL	IRE	Approximate Interval Between Onset and Death
P.O. Box 68	The law requires thet the death certificate be executed ate has been signed by the ettending physicien end page 2 should be deteched for use as the burial-transit	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome of pregnar 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de 9 ☐ Unknown	death 3	Ectopic pregnancy	,		23d. Date of deli- Month	very Day Year
cords, P	w requires the been signed t should be det		Part II. Other significant conditions co	ntributing to death but not resu	iting in the ur	nderlying cause giv	en in Part I.	23e. Did toi 1 ☐ Yo 24a. Wasa		obably 4 Unknown
Division of Vital Records,		Be Completed	25. Was case referred to medical examiner?				26. Place of Death	autops perform 1  Yes	med? death? 2 No 1 Yes	topsy findings available completion of cause of
n of	Phys this al di	ဥ	1 ☐ Yes 2 ☐ No  27. Manner of Death 1 ☐ Natural 5 ☐ Pending		R/Outpatien 28b. Time of Injury	28c. Injur Wor	y at		ence 6 Other (Specow injury occurred	ufy)
Divisió	at or Attending s efter death. ii Director: After id in by the funer	Certification;	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	me, farm, stre		Yes 2 □No	28f. Location (SI City or Town	treet and Number or Ru π, State)	ral Route Number,
	To the Hospitat or Attending within 24 hours efter death.  To the Funerel Director: Atter completely filled in by the funer	Medicai (	29a. Certifier (Check only one)  2 Medical Exam  29b. Signature and title of certifier	sician: To the best of my know iner: On the basis of examination and manner stated.	vledge, death ion and/or inv	occurred at the tirvestigation, in my o	pinion, death occurr	ed at the time, d	ause(s) and manner as date and place, and due	to the cause(s)
)	7 1 3 1 8		30. Name and address of person who c	Completed cause of death (Item			57/2		3/9/0	
	Sta	te	Truong Bao, M.D.  31. Date filed (Month, Day, Year)	9715 Medical  32. Registrar's Signat	Center		Rockville	, Maryl	and 20850	
DH	Registr MH 17 Rev 1/2		MAR 1 3 20	106 /						
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DHMH 17 Rev 1/2001

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			For State	State of Ma	ryland /				d Mental I	Hygien	ie o o c	gray array same termy you
			1 - State Registrer			Certif	icate of	Death		Reg. N	16-UUD	01016
			1. Decedent's Name (First, Middle, Las	1)					2. Date o		ay Year	3. Time of Death
	Physici /Medio		GENEVA				WILLIA	MS	MARC		9 2006	17:54 M
)	Examir		4a. Facility Name (If not institution, give	street and number)		41	. City, Town, o	or Location of D	Death	4	c. County of Deat	h
			The Johns Hop	Kins Hos	spital		altin	nore (	Lity		N/A	
	Funeral		Social Security Number     6. Se	x 7. Age ☐ M 2☐ F	(In yrs. last b	M	Under 1 Year onths Days			f Birth Day, Yea	9. Birt	hplace (State or Foreign untry) MD
	Director		21/ 00 34 93		46	Yrs.			MAY MAY	29,	1959	MD.
	and *		Usual Residence of Decedent  10a. State 10b. County		10c. City, Tox	wn or Locati	on .					10d. Inside City Limits
	tary!	ក	MD. N/A		-	OMIT						X□Yes 2□No
	r 280-f ehow	ect	10e. Street and Number				Of. Zip Code			100.0	Citizen of What Co	
	with	Funeral Director	857 HILLMAN COL	שמז			21202	)		rog. c	USA	unity:
	eath	era		12. Was Decedent E	ver in IIS	13 Was			2 (Specify Ves o	r No-	14. Race - Ame	nican Indian
	iten d	ij.	11. Marital Status  1	Armed Forces?		If Ye	s, specify Cub	an, Mexican, F	? (Specify Yes of Juerto Rican, etc.	)	Black, White	
21215-0036	within 72 hours after death with the Maryland ane. than "naturel", or iteme 23a or 28e-f ehow ha Madical Exeminar must be notified at	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	-	1 🗆	Yes 2X No	Specify:			Specify: BL	ACK
ŏ	2 hou	pe	15. Decedent's Ed	ucation	16	a. Decedent	's Usual Occu	pation		16b.	Kind of Business/	Industry
15	nin 7.	Completed	(Specify only highest grade Elementary/Secondary (0-12)	de completed) College (1-4or 5+		(Give kind life. DO	f of work done NOT use retire	during most of d)	working			
212	filed with Hygiene other the	E	10TH	College (1-401 34	'	HOUS	EKEEPI	ER		JAI	NITORIA	L BUSINESS
ğ	be filed withi tal Hygiene. d other than event, the M	Be C	17. Father's Name (First, Middle, Last)					18. Mother's	Name (First, Mi	ddle, Maide	en Sumame)	
a	should be file nd Mental Hy marked oth imatic event	ToE	HARVEY CI	ROSS				HEST	ER WIL:	LIAM	S	
Maryland	s 1 and 2 should f Health and Men Item 27 ie marke other treumatic		19a. Informant's Name/Relationship (7	ype, Print)	19	b. Mailing A	ddress (Street	and Number o	or Rural Route No	umber, City	or Town, State, 2	Zip Code)
	alth a		TIFFANY CAMPBE	LL ( DAUGHT	ER) 3	51 S	. SPRI	ING CO	URT BA	LTO,	MD. 2	1231
Baltimore,	es 1 an of Heat fitem 2 r other		20a. Method of Disposition 1 ⊠ Burial 2 ☐ Cremation 3 ☐	Pamoual from State	20b. Place cemet	of Disposition	n (Name of any or other pla		Date		Location - City or	
Ĕ	Pag nent ant: fi		4 Donation 5 Other (Specify		MT.Z	ION	CEM.	MA	R.17,2	$006_{\mathrm{B}}$	ALTIMOR	E,MD.
ati	permit. Pages Depertment of Important: If i any injury or o		21. Signature of Funeral Service Licen:	See		22. N	me and Addre	ss of Facility	UCGS FI	INFR	AL HOME	
Œ	Den gun		Dernadine	Il fore	wor						LTO, MD.	21213
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	lications that caused to	the death. Do							Approximate Interval Between
,	Physician		Immediate Cause (Final disease or condition	. INFLUE		4						Onset and Death
1	/Medical		resulting in death)	Due to (or as a		of):						3 WEEKS
	Examiner		A CONTRACTOR OF THE PROPERTY O	MORBI	0 01	RESITY	,					20 YEARS
		Jer	Sequentially list conditions, if any, leading to immediate	Due to (or as a	consequence	of):						
O	outed id ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	C.								
Ó	te be executed ysicien and ie burial-transit		resulting in death) Last	Due to (or as a	consequence	of):						
,092	ysicie	cal	(	d								
Вох	The law requires thet the death certifica Ne hes been signed by the ettending ph age 2 should be detached for use as t	Physician/Med	230. was decedent pregnant	23c. If yes, outcome of		h 3∏⊑⊲	opic pregnanc				23d. Date of del	ivery
<u>.</u>	deati	100	in the past 12 months? 1 2 Yes 2 XNo	4□Pregnant at t			ner (specify) _	,		_	Month	Day Year
P.0	by the de	hy	9 ☐ Unknown	9CI OTIKTIOWIT								
Ś	es the gned be de	by F	Part II. Other significant conditions of	entributing to death but	t not resulting	in the unde	lying cause gr	ven in Part I.	23e. l	Did tobacci	o use contribute to	the cause of death?
ğ	v require been sig	pe							_	I 🗌 Yes	2 1 No 3 □ Pr	obably 4 Unknown
o O	aw re is be 2 sho	Completed								Was an	24b. Were au	topsy findings available
æ	The lav te hes	E							1 .	autopsy performed? es 2 <b>X</b> 1	death?	completion of cause of
Division of Vital Records,		0	25. Was case referred to medical					26. Place of	Death (Check o		10 103	2010
⋛	Physicien: r this certific ral director,	To B	examiner?	Hospital:	t 2 🗆 ER/C	outpatient	DOA OS	200			6 ☐Other (Spe	cifv)
0	g Ph er thi	L L	27. Manner of Death	28a. Date of Injury (Month, Day		Time of	28c. Inju Wo				jury occurred	,/
Ö	5 5 5	ate	1 Natural 5 ☐ Pending 2 ☐ Accident investigation		7 647)	Injury		Yes 2 □No				
<u>Vis</u>	Atte	E C	3 ☐ Suicide 6 ☐ Could not be determined	286. Place of inju	ry - At home,	farm, street,	factory, office					ural Route Number,
Ō	s afte	Certification:		building, etc.	(Spacity)				City o	r Town, Sta	310/	
	Hoepital		29a. Certifier 1 Certifying Ph	sicien: To the best of	my knowled	ge, death oc	curred at the ti	me, date and p	lace, and due to	the cause	(s) and manner as	stated.
	To the Hospital or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fi	Medical	(Check only 2 Medical Examone)	iner: On the basis of and manner stat	examination a	nd/or invest	gation, in my	opinion, death	occurred at the t	me, date a	ind place, and due	to the cause(s)
_	To the within 2 To the complet	Σ	29b. Signature and title of confifier				29c. Licen:	se number		29d. [	Date signed (Mont	h, Day, Year)

09. 2006

RES -MEDICAL DOCTOR 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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32. Registrar's Signature

NORTH WOLFE BALTMORE

000

State Registrar

MAR 1-3 2006

31. Date filed (Month, Day, Year)

KRISHNAS WAMY

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			For State Registrar	State of Marylan	-		f Health and of Death	•	giene Rag. No.	6 07577
	Physici /Medio Examin	al	1. Decedent's Name (First, Middle, Last)  Fred E  4a. Facility Name (If not institution, give si	1 00 11.		0 111	m, or Location of Deat	2. Date of De Month Marc	. Day	/ear 3. Time of Death OO6 11.555 AM Death N / A
der	Funeral Director		5. Social Security Number 406-52-2581  Usual Residence of Decedent	7. Age (In yrs. 1	Yrs.	If Under 1 Ye Months Da		8. Date of Bir (Month, Da SEP 1,	th Ly, Year) 1942	Birthplace (State or Foreign Country) Kentucky
Wilder	the Marylar 28a-f show	ector	10a. State 10b. County  Florida Saint Jo  10e. Street and Number		y, Town or Loc		E1kton		10- 05	10d. Inside City Limits 1  Yes 2 No
202	3a or	급	4947 Cypress Link	s Boulevard		10f. Zip Coo	32033		10g. Citizen of Wh	•
as Fred 5-0036	s 1 end 2 should be filed within 72 hours after death with the Maryland f Heelth and Mental Hygiene. If Heelth and Mental Hygiene. If files 72 is marked other than "natural; or items 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at	by Funeral Director		2. Was Decedent Ever in U. Armed Forces?  1 □ Yes 2 □ No If Yes, Give X Year or Dates:	1		of Hispanic Origin? (S Cuban, Mexican, Puer No Specify:	pecify Yes or No to Rican, etc.)		American Indian, White, etc. White
~ E	within 72 ho ene. than "natur in Medical	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)		(Give k		ccupation one during most of wo stired) Executive	rking	16b. Kind of Busi	ness/Industry ne Company
Maryland 212	ould be filed of Mental Hygie arked other atic event,	To Be Co	17. Father's Name (First, Middle, Last)  Fred B. Wilder,	Sr.	TRIER	eting.	18. Mother's Na	me (First, Middle) Lee Shar	, Maiden Surname,	
1 -	end 2 should I eelth and Meni m 27 le marke		19a. Informant's Name/Relationship (Type Lyda W. Wilder/Wif	рө, Print) e	4947	Cypre	reet and Number or Ri SS Links B	ural Route Numb oulevard	er, City or Town, S. Elkton,	FL 32033
Patitore.	Page nent o ant: if		20a. Method of Disposition  1 ☐ Burial 2 ☑ Cremation 3 ☐ Re 4 ☐ Donation 25 ☐ Other (Specify)	mioval holfi State	Place of Disposementary, crem		f place) Inc. 3/13	Date 3/06	20c. Location - C	ity or Town, State
T Ball	permit. Departr Imports eny inte		21. Signature of Funeral Service License	orchik			ddress of Facility C ederick Ro			of MD, Inc. D 21228
.8760.	Physicien: The law requires that the death certificate be executed with this certificate has been signed by the attanding physicien and unique to should be detached for use as the burial-transit to be unique to the certificate has been signed by the attanding physicien and the certificate has been signed by the attanding physicien and the certificate has been signed by the attanding physicien and the certificate has been signed by the attanding physicien and the certificate has been signed by the cert	dical Examiner	23a. Part1. Enter the disease, or complic shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, resulting to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequ	Suence of):		in Car	c or respiratory a	rrest,	Approximate Interval Batween Onset and Death O Q Y
P.O. Box 6	that the death certifica ed by the attanding ph detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of do 9 ☐ Unknown	Ideath 3	Ectopic pregni Other (specif)			23d. Date Mont	
	w requires that been signed t	þ	Part II. Other significant conditions conditions	tributing to death but not resi	ulting in the un	derlying cause	e given in Part I.	23e. Did 1	/	oute to the cause of death?  B Probably 4 Unknown
Division of Vital Becords.	ysicien: The law ris certificate has be director, page 2 sh	e Completed	25. Was case referred to medical					1 ☐ Yes	2 No 1	ere autopsy findings available or to completion of cause of ath?
<u>=</u>	ysicie s certi directo	To Be	evaminer?	ospital:	ER/Outpatient	3□ DOA	Cthos	ath <i>(Check only o</i> Home 5 □ Besi	o <i>ne)</i> idence 6 ⊟Other	(Specify)
sion of	ding After fune		27. Manner of Death  1 Natural 5 Pending investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c.	Injury at Work?		how injury occurred	
Divis	To the Hospital or Attending within 24 hours efter death.  To the Funeral Director: After completaly filled in by the fune.	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At ho building, etc. (Specify	y) 			City or To	wn. State)	or Rural Roule Number,
	the Hosp in 24 hou the Fune ipletaly fi	Medical	(Check only 2   Medical Examin	ician: To the best of my kno par: On the basis of examina and manner stated.	wledge, death tion and/or inv	estigation, in r	my opinion, death occ	e, and due to the urred at the time,	date and place, an	d due to the cause(s)
	To voice	2	29b. Signature and title of certifier				cense number			(Month, Day, Year)
	47		30. Name and address of person who con	mpleted cause of death (Item	1 23a) (Type, F		2S-00C	1-11	March	11,2006
	Sta Regist	ate rar	31. Date filed (Month, Day, Year)  MAR 1-3 200	32/Registrar's Signa	vure do	Spita	1 of Do	21 Time	ore	

			For State Registrar	State of Marylar		nt of Health and te of Death		giene	07578
	Physici /Medio		1. Decedent's Name (First, Middle, Last	D, WI	hitfiel		2. Date of Dea Month MARCH	H 11, EQQ	
7	Examir	ier	4a. Facility Name (If not institution, give Saint Joseph	Medical Cer	nter	7, Town, or Location of Deat	on		timore
	Funeral Director		5. Social Security Number 6. Se 7.7-76-76-77  Usual Residence of Decedent	X 2□F 7. Age (In vrs.	Yrs. If Und	er 1 Year If Under 24 Hrs Days Hours Min.	8. Date of Birth (Month, Day	8,1966 m	thplace (State or Foreign ountry) aryland
	Maryland e-f ehow	ctor	10a. State 10b. County Balti	more 10c. E	ity, Town or Location Co Ckey	suille			10d. Inside City Limits 1 ☐ Yes 2 No
	th with the 23e or 28	Funeral Director	10e. Street and Number  G Gingervier	oct. Apt	€ 10t/ Z	1030	1	0g. Citizen of What C	ountry?
036	within 72 hours after death with the Maryland ene. then "neturel", or items 23e or 28e-f ehow he Madical Exeminer must be notified at	۾	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1 Tes 2 No If Yes, Give Year or Dates:	J.S. 13. Was Dec If Yes, sp	edent of Hispanic Origin? (Secify Cuban, Mexican, Puer 2000)	pecify Yes or No- to Rican, etc.)	14. Race - Am Black, Whi Specify: P	
21215-0036	filed within 72 ho Hygiene. ther then "netui ont, the Medical	Completed	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12)	cation e completed) College (1-4or 5+)	16a. Decedent's Us (Give kind of w life. DO NOT Super	rork done during most of wo use retired)	rking	16b. Kind of Business Found	
Maryland 2	ould be filed I Mental Hygid varked other	To Be C	17. Father's Name (First, Middle, Last)	whitfie	LD	18. Mother's Nai	me, (First, Middle,	Maiden Sumame) Burley	<i>U</i>
	ies 1 and 2 shoof Health and of Health and If Item 27 ie mor or other traum		19a. Informant's Name/Relationship (7)  Bernice Burley in 1990  20a. Method of Disposition 1990  1990	itfeld - mother 20b.	Place of Disposition (Nacemetery, crematory or	other place)	ural Route Number  Date  14-06	r, City or Town, State,  email M  20c. Location - City or  Batterno	d, 21223 Town, State
Baltimore	permit. Page Department of Importent: If eny injury or once.		4 Donation 5 Other (Specify, 21. Signatur Uneral Service Licens	//			20 Fred ,	+1LTon &	Pass to md, 21229
	Physician /Medical		23a. Pari / Enjer the disease, or comp shock, or heart failure. List only o Immediate Cause (Final disease or condition resulting in death)	RESPIRATO	DRY FAILU	ode of dying, such as cardia			Approximate Interval Between Onset and Death
	Examiner	-	Saquantfally list con-Micros	Due to (or as a consecutive PNEUMONIF	- transprace				
,092	ate be executed hysicien and the burial-transit	icai Examiner	f any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conse					
P.O. Box 687	death certific e attending p id for use as l	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	:3c. If yes, outcome of pregn 1	al death 3 □Ectopic			23d. Date of de Month	livery Day Year
	signed be de	þ	Part II. Other significant conditions co	ntributing to death but not re	sulting in the underlying	cause given in Part I.		bacco use contribute t es 2X No 3 ☐ P	o the cause of death? robably 4 []Unknown
Il Records,		Completed					24a. Was a autops perform	sy prior to death?	utopsy findings available completion of cause of 2 No
Vital	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	lospital: 🕶		Other	ath (Check only or		200
of	nding Phys th. r: After this e funeral di	ation; To	1 Yes 2 No  27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	1 Inpatient 2 2 28a. Date of Injury (Month, Day Year)	ER/Outpatient 3 0 0 28b. Time of Injury M	28c. Injury at Work? 1 Yes 2 No		ence 6 □Other (Spe ow injury occurred	icify)
Division	To the Hospital or Attanding within 24 hours effer death.  To the Funarei Director: Atter completely filled in by the funer	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Speci		ry, office	28f. Location (S. City or Town	treet and Number or R n, State)	ural Route Number,
	he Hospi in 24 hou. he Funar pletely fill.	Medical	29a. Certifying Phy (Check only one) 1 ☑ Certifying Phy 2 ☐ Medical Exam	sician: To the best of my kn ner: On the basis of examin- and manner stated.	owledge, death occurre ation and/or investigatio	d at the time, date and place n, in my opinion, death occu	e, and due to the curred at the time, d	ause(s) and manner a late and place, and du	s stated. e to the cause(s)
	To t With Com	Σ	29b. Signature and title of certifier	7/1	25	C. License number	2	9d. Date signed (Mon	
0	X		30. Name and address of person who c	ompleted cause of death (Ite	m 23a) (Type, Print)	D 30263		03-11	
0	Sta Registi		FRANCIS TAT-TE 31. Date filed (Month, Day, Year)  MAR 1 3 20	E KHOO, M. I 32. Registrar's Sign	)., 7601 (	OSLER DRIVE	. TOWS	ON, MARYL	AND 21204

DHMH 17 Rev 1/2001

ORIGINAL

			For State Registrar		State	of Mary					ealth a Death	and M	lental Hy	giene Reg. No.	06	0757	9
	Dhyoini		Decedent's Name (First,	Middle, Las	it)								2. Date of De Month	ath Day	Year	3. Time of D	
	Physicia /Medic			1500									MARCH	5 8	2006	12.31	4. M
	Examin	er	4a. Facility Name (If not insi		street and nu	ımber)		4			Location of	of Death		4c. Co	unty of Deat	th	
			5. Social Security Number	FV€ 6. S	ex	7. Age (/r	yrs. last birti	hdav)	If Under 1	Hmo Year	R &	24 Hrs.	8. Date of Bir	th	-/-	thplace (State or	Foreian
	Funeral Director		250 40 6950		M 2□F		_		Months	Days	Hours	Min.	Month, Pa	y, Year)	Co	Jokidles	
	P.		Usual Residence of Decede											417			11-11-
	arylar ehow	_	10a. State 10b. C	ounty		_	c. City, Town		ation							10d. Inside City	
	the M	Director	10e. Street and Number	V/a			SA/tim	URE	10f 7in (	Code				10g. Citizen	of What Co	nuntry?	
	a or 2			1.10					10f. Zip (					UES.		Jurilly !	
	ns 23	Funeral	702 GOLSUCK	HUE	12. Was Dec		r in U.S.	13. Wa			ispanic Ori	gin? (Sp	ecify Yes or No Rican, etc.)		Race - Ame	erican Indian,	
21215-0036	within 72 hours after death with the Maryland iene. r then "natural", or Itams 23e or 28e-f ehow the Medicel Examinat rivist be rictified at	by	1 Never Married 2		Armed F 1 Tes If Yes, G Year or I	2 ZHO					Specify:	i, Puerto	Rican, etc.)		Black, White Black	e, etc.	
2-0	72 ho	eted	15. De	edent's Ed	ducation de completed	()	16a.	Deceder	nt's Usual	Occup	ation during mos	t of work	ina	16b. Kind	of Business	/Industry	
21	within sene.	Completed	Elementary/Secondary (	- i		(1-4or 5+)		lite. DO	O NOT use	e retired	1)		9	P		. /.	
			77L	iddle Leat	(	0	H	UUSIA	v 5		19 Moths	er's Name	e (First, Middle	BATHIN		<i>M</i>	
ano	ed all all all all all all all all all al	o Be	17. Father's Name (First, M								1.			, Maidell Su	isiailiej		
Maryland	S ≥ 80 10	7	19a, Informant's Name/Rei	TKEL ationship (	Type, Print)		19b.	Mailing	Address	(Street			A Route Numb	er, City or To	own, State,	Zip Code)	
Ma	nd 2 shouth and 27 is m			1,150N	,		70	-	_				homene A				
ē,	es 1 an of Heal fitam 2 r othar	4	20a. Method of Disposition			i i	20b. Place of	Disposit		e of			Date			Town, State	
Baltimore	Pagent ent ht: h		1 Burial 2 □ Crem '4 □ Donation 5 □ Ot				King Mei				· 1	3/10/	106	BAITIN	NURE 1	ND	
alti	permit. Pa Departmen Important: any injury once.		21. Signature of Funeral Si	rvice Licer	ns <del>ee</del>	,	1	22. 1	Na <i>m</i> e and	Addre	ss of Facili	y Bt	106 45 Fune	nil H	eme		
-	Dep Imp any		Sotica					118	29 N.	V 17.			BA Hime		210		
			23a. Part1. Enter the diseasonck, or heart failure	se, or com . List only												Approximate Interval Betw Onset and D	reen
	Physician		Immediate Cause (Final disease or condition resulting in death)  END STACE CONGESTIVE HEART FAILURE  Due to (or as a consequence of):  Chronic Obstructive Rulmonary Disease 465  Due to (or as a consequence of):  Due to (or as a consequence of):											?			
	/Medical Examiner		,	- (	Due to	o (or as a c	onsequence o	of):	Suc.	tiv	e A	2/n	MAN	J/36	PASP	UPS	
	,	er	Sequentially list conditions if any, leading to immediat		Due to	o (or as a c	onsequence	of):						, ,,,	0100	700	
	be executed sician and burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	1	· Hy	ner	TENS onsequence	510	لر							405	
ó	e exerian ar		resulting in death) Last		Dyleto	o (or as a c	onsequence	of	/	-		. //	cien			110	
8760	ate be hysic the bu	lica		•	d. Ch.	ron	ic x	en	M	<u>_</u>	USU	117	cien	y		92	
9 x	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE:		23c. If yes, o	utcome of	pregnancy								Data al da	i e	
Вох	atten for us	cian	23b. Was decedent pregna in the past 12 months		1 🗀 Live		Fetal death		Ectopic pre		1			230	I. Date of de Month		ear
o.	that the de ed by the detached	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown		9□ Unk				outor (ope								
Δ.	es that igned b		Part II. Other significent c	onditions	contributing to	death but r	, ,		, ,	-		l.	23e. Did	tobacco use	contribute t	o the cause of de	ath?
rds	quires in sign uld be	d be	Gout, 1	0/1	MOWA	my,	Hype	21	Lew.	510	N		10	Yes 2□	No 3□P	robably 4 🔼	nknown
Records,	aw requisite speen	piet					1						24a. Was		24b. Were a	utopsy findings a completion of ca	variable
Re	9 4	Completed by											perf 1 ☐ Yes	ormed?	death?	-	1000 01
Vital	Physician: The this certificate ral director, pag	Be C	25. Was case referred to n examiner?	nedical								e of Deal	h (Check only				
of V	Physic this co	ဥ	1 ☐ Yes 2 ♣ Ho			Inpatient	2 ☐ ER/Ou	-		^	- triangle	ursing Ho	ome 5 🗷 Res			ecify)	
	Jing P	ion:		Pending		e of Injury onth, Day Y	ear) 28b.	Time of njury	M 2	8c. Injur Wor	rk?	No	28d. Describe	how injury o	ccurred		
Division	Attanding ir death. actor: Alte by the fune	Certification:	# C 7 100100111	nvestigatio Could not b	e ge Bla	ce of Injury	- At home, fa	ırm strei			Yes 2□	140	28f Location	(Street and I	lumber or A	lural Route Numl	ber.
<u>&gt;</u>	l or Attanc after death Diractor:	ertif	4  Homicide	determined	buil	lding, etc. (	Specify)	, 5,16	ot, lactory	, ornes				wn, State)			.,
	To the Hospital or Attanding Physician: within 24 hours after death.  To tha Funarai Diractor: After this certific completely filled in by the funeral director,												and due to the				
	ne Ho n 24 h na Fu	edical	one)		and ma	anner state	d.									e to the cause(s)	
	To the within To the comp	Me	29b. Signature and title of Color of the Col	certifier	Reil	lly	MI	0	290	Licens	se number	74	9	29d. Date s	orgned (Mon	th, Day, Year)	6
7	5		30. Name and address of	erson who	completed ca	use o dea	th (Item 23a)	Type, P	Print)	N	,		1- 1	2.11	14000	inn -	1770
_	)		ALIEN REL	Ly,	MU,	46	45T K	2011	ing	6	1055	Koa	as, C	ast	mure	,000 2	
		ate	31. Date filed (Month, Day	Year)	32.	Registrar's	Signature										
	Regist		MAR	132	006	No.	K	1	248	,							
D.	HMH 17 Rev 1/2	2001				J. 200 W.		1	-								
ان							OBI	GINA	L								

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		1 - State Registrar		Ce	ertificate of	Death	R	leg. No.	b U/	5 8 U
Physi	ician	1. Decedent's Name (First, Middle, L					2. Date of Dea Month		/ear	ne of Death
•	dical		Emm	it Arnold,	Jr.			Mar 6, 2006	10:	15 р м
Exam	niner	4a. Facility Name (If not institution, g			4b. City, Town, o	or Location of Death		4c. County of		
			st Center for Hos	•	KIII-I-I	Tow			Baltimore	
Funera Directo		253-24-1481	Sex 7. Age 1 DxM 2 ☐ F	(In yrs. last birthda)	Months Days	Hours Min.	8. Date of Birth (Month, Day Jan 20	), Year) 0, 1921	9. Birthplace (St Country) Georg	
and		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or I	ocation				10d. Insid	de City Limits
Maryl 1 ehc	٥	Maryland i-	loward			Columbia			10	Yes 2□No
176 128a	Je C	10e. Street and Number			10f. Zip Code		1	log. Citizen of Wh	at Country?	
3a or	<u></u>	6161 Night Street HIII				21045		•	U.S.A.	
death me 2	Funeral Director	11. Marital Status	12. Was Decedent E	ver in U.S. 13	. Was Decedent of I	Hispanic Origin? (Spe	ecify Yes or No-		American India	ın,
after or representation		1 ☐ Never Married 2 ☐ XMarried		° 1942		an, Mexican, Puerto	Rican, etc.)		White, etc.	
ours Frail;	d by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	1946	1 □ Yes 2 □XNo	Specify:		Specify:	Black	
72 h	Completed	15. Decedent's (Specify only highest g	Education trade completed)	16a. Dec	edent's Usual Occup e kind of work done	pation during most of working)	ing	16b. Kind of Busi	ness/Industry	
vithin hen	E G	Elementary/Secondary (0-12)	College (1-4or 5+	-) life.		aborer		Clot	thing Indust	try
if it is a factor of the Maryland Hygiene, with the Maryland Hygiene, then then 'natural', or items 23s or 28s-1 ehow ont, the Medical Examinat must be notified at		12 17. Father's Name (First, Middle, Las	et)			18. Mother's Name	(Eight Middle	Maidan Cumama		
d be f	Be		nit Arnold			To. Mottrer's realite		sie Shehield		
should and Men marke	ဥ	19a. Informant's Name/Relationship		19h Mai	ling Address (Street	t and Number or Rura				
id 2 s ith ar 27 is trau		Theresa Arnold, Jr. V				reet Hill Colum			ate, 21p 000e)	
ges 1 and 2 should be filed within 72 hours after death with the Marylan (of Heelin and Mental Hygiene.)  1 of Heelin and Mental Hygiene.  2 of Heelin 21 is marked other than 'natural', or iteme 23a or 28a-1 ehow or other traumatic event, the Medical Examinar must be notified at		20a. Method of Disposition		20b. Place of Disg	osition (Name of	! 0	_	20c. Location - C	ity or Town, Stat	te
9°= 5		1 D'Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spec			ematory or other pla Imbia Memoria	1/2	03/13/06	Clarks	rksville, Maryland	
		21. Signature of Funeral Service Lic		The second secon	22. Name and Addre	ur r uris			, , , , , ,	
per it. Departr Importa	a	>EMOONO	, XC . 1X.77	20 Kepla	Estep I	Brothers Funer Eutaw Place Ba	ral Service,	P. A.		
		23a. Part1. Enter the risease, or co shock, or hear thilure. List only	mplications that caused t	the death. Donn e					Approx	imate
Physicia		Immediate Cause (Final	y one cause on each line		cer					and Death
/Medica	al	disease or condition resulting in death)	Due to (or as a	consequence of):					year	25
Examine	r	0					/			
n =	ne ne	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury								
ocuted nd trans	Examiner	that initiated events								
e exe		resulting in death) Last	Due to (or as a	consequence of):						
ate b hysic	Ca		d							
certificate be executed ding physicien and ise as the burial-transit	/Medical	IF FEMALE:								
		22h Was desadent normant	23c. If yes, outcome o	Fetal death 3	Ectopic pregnanc	у		23d. Date Monti		Year
the a	Physician	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at t 9□Unknown	ime of death 5	Other (specify) _				. 52,	1001
Attending Physician: The law requires that the death in daath in a road and a state of the action of the attendence of t		Part II. Other significant conditions	contributing to death but	t not resulting in the	underlying cause on	ven in Part I	23e Did to	bacco use contrib	ute to the cause	of death?
sign d be	db		, , , , , , , , , , , , , , , , , , ,		ondonying addoor git	Total Care I.	1 □ Ye	11	_	4 ⊟Unknown
w require been si should t	ete							N		
hes hes	Completed						24a. Was a autops perform	in 24b. We sy pri	ere autopsy lindi or to completion ath?	ngs available of cause of
n: Tr ficate fr. pag			,				1 ☐ Yes	2) No 1 E	Yes 2□ No	
hysician: The Is his certificate he I director, page 2	Be	25. Was case referred to medical examiner?	Hospital:			26. Place of Death				_
Physical distribution	5	1 ☐ Yes 2 🕅 No 27. Manner of Death	1 ☐ Inpatien 28a. Date of Injury		RII 3 DON	4 🗀 Nursing Hor			(Specify) LOS	file
ding Ph th. After th funeral	to to	28a. Date of Injury 28b. Time of 28c. Injury at 28d. Describe how injury 28b. Time of 28c. Injury at 28d. Describe how injury 3								
dear dear ctor: y the	fica	3 Suicide 6 Could not be determined 28e. Place of Injury, - At home, larm, street, factory, office 28l. Location (Street and Number or								Number
E 2 4 6	Certification:	building, etc. (Specify)  City or Town, State)								
Hospital 24 hours a Funerel I tely filled										
the Ho hin 24 t the Fu	edical	(Check only 2 Medical Exa	aminer: On the basis of e and manner state	examination and/or i	nvestigation, in my o	pinion, death occurre	ed at the time, d	ate and place, an	d due to the cau	se(s)
To the withing To the comp	ž	29b. Signature and little of certifier	11.	-	29c. Licens	se number		9d. Date signed (	Month, Day, Yea	ar)
			uun			58303	/	narch -	7 2006	?

DHMH 17 Rev 1/2001

State

Registrar

30. Na e and address of person who completed cause of death (Item 23a) (Type, Print)

AANON CAMELY BY 6661 N Charles St Born were MY ZNAY

2. Registrar's Signature

Afron Cuncer im

MAR 1 4 2006

31. Date filed (Month, Day, Year)

		1 - State of M		partment of Health and M e <i>rtificate of Death</i>	lental Hygier	2000	07582
Phys	ician dical	Decedent's Name (First, Middle, Last)     LEONARD	Ε.	ALBERT	2. Date of Death MARCH 10	Day 2006 Year	3. Time of Death 2:40 P M
).	niner	4a. Facility Name (If not institution, give street and number, HOSPICE OF BALTIMORE GILCH	RIST CTR.	4b. City, Town, or Location of Death TOWSON			ΓΙMORE
Funer Direct		216-20-2967 <sup>1</sup> X <sup>M 2□ F</sup>	ge (In yrs. last birthda 78 Yrs.	y) If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day, Yea JUN. 17, I	9. Birthp 927	place (State or Foreign http) MD
aryland	2	Usual Residence of Decedent  10a. State  10b. County	10c. City, Town or			1	0d. Inside City Limits 1 ☐ Yes 2 ☑ No
death with the Maryland me 23e or 28e-f show	Director	MD BALTIMORE  10e. Street and Number	BAI	LTIMORE  10f. Zip Code	10g.	Citizen of What Cour	ntry?
<u>ĕ</u> ≅ ≅	by Funerai	6 STIRRUP COURT  11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced  12. Was Decedent Armed Forces 1 Married 1 Married 1 Married 2 Married 1 Married 2 Married 1 Married 1 Married 1 Married 2 Married 1	No NAVY	21208 3. Was Decedent of Hispanic Origin? (Spiff Yes, specify Cuban, Mexican, Puerto 1 □ Yes 2 No Specify:	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White, Specify:	
15-00 in 72 hou n "natura	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Dec	cedent's Usual Occupation ve kind of work done during most of work i. DO NOT use retired)	ing 16b.	. Kind of Business/In	dustry
Baltimore, Maryland 21215-0036 bernit. Pages 1 end 2 should be filed within 72 hours all beperiment of Health and Mental Hygher then "netural; or may injury or other treumstic event, the Medical Expending violury or other treumstic event, the Medical Expending violury or other treumstic event, the Medical Expending violury or other treumstic event.		Elementary/Secondary (0-12)  College (1-4or  5+  17. Father's Name (First, Middle, Last)	5+)	TY-HEALTH & MENTAL	HYGIENE	STATE GOV	/ERNMENT
rylane nould be in Mental	To Be	IRVING E.	ALBEI	RT ANNA			KEMPER
end 2 sh end 2 sh ealth and m 27 is n		19a. Informant's Name/Relationship (Type, Print) IRMA ALBERT / WIFE	6 9	STIRRUP COURT - BAL	TIMORE, M	D 21208	
imore Pages 1 nent of H ant: If ite		20a. Method of Disposition  1 ☼ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	cemetery, ci	position (Name of rematory or other place) MEMORIAL PARK 03/1		RANDALLS	
Balti permit. Depertr Importe	Succession	21. Signature of Funeral Service Licensee		22. Name and Address of Facility SC 8900 REISTERSTOWN	L LEVINSO		
Physicia		23a. Part1. Enter the disease, or complications that cause shock, or heart failure. List only one cause on each Immediate Cause (Final disease or condition resulting in death)	ine.				Approximate Interval Between Onset and Death
/Medic Examine		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	s a consequence of):				0
S/10/06  x 68760,  certificate be executed ding physicien and use as the burial-transit	dicai	that initiated events	s a consequence of):				
Geath death	Physician/Me		2 Fetal death 3	3 ⊟Ectopic pregnancy 5 □ Other (specify)		23d. Date of delive Month	ory Day Year
rds, P quires that n signed t	þ	Part II. Other significant conditions contributing to death I	but not resulting in the	underlying cause given in Part I.		o use contribute to the	ne cause of death? ably 4 Unknown
Vital Records, P.O vital Records, P.O sicien: The law requires that the certificate has been signed by the rector, page 2 should be detach.	Completed				24a. Was an autopsy performed	prior to co death?	psy findings available mpletion of cause of
T P y g in is	ation: To Be	25. Was case referred to medical examiner?  1   Yes   2   No	ient 2 ER/Outpati ury 28b. Time ay Year) Injury	ient 3 DOA Other: 4 Nursing Ho	n (Check only one) me 5 Residence 28d. Describe how in		n Hospice
Division Division pitel or Attending ours after death. eral Director: After	Certification:	3 Suicide 6 Could not be determined 28e. Place of In building, e	jury - At home, farm, s tc. <i>(Specify)</i>	street, factory, office	28f. Location (Street City or Town, St		l Route Number,
To the Hospitel within 24 hours a To the Funeral I completely filled i	Medicai	29a. Certifier (Check only one)  1 Certifying Physician: To the best 2 Medical Examiner: On the basis of and manner st	of examination and/or	ath occurred at the time, date and place, investigation, in my opinion, death occurr	and due to the cause red at the time, date a	e(s) and manner as s and place, and due to	tated. the cause(s)
To the Within To the Comp	×	29b. Signature and title of certifier  About the signature and title of certifier  About the signature and title of certifier  About the signature and title of certifier  About the signature and title of certifier  About the signature and title of certifier  About the signature and title of certifier  About the signature and title of certifier  About the signature and title of certifier  About the signature and title of certifier  About the signature and title of certifier  About the signature and title of certifier  About the signature and title of certifier  About the signature and title of certifier  About the signature and title of certifier  About the signature and title of certifier  About the signature and title of certifier  About the signature and title of certifier  About the signature and the signatu	mo	e. Print) Charles St.	29d. [	Date signed (Month,  1 Arch 1	Day, Year) 0, 2006
17		30. Name and address of person who completed cruse of the state of the	death (Item 23a) (Typi 10 6 2 6 7 rar's Signature	N. Charles St.	Balts.	and 21.	20%
Regi	State strar	MAR 1 4 2006	rais Signature	berli			
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			For State Registrar	State of Ma		l / Depa		t of He	ealth a			gien Reg. N	0000	0	7583
*	Physicia /Medic	_	Decedent's Name (First, Middle, Last)     CHARLES		Α.			BAUGH		4.50-146	2. Date of Dea Month MARCH	11,	2006 Ye	ar 3	Time of Death: 37 A M
A. W.	Examin Funeral Director	er	4a. Facility Name (If not institution, give s 2103 CAVES ROAD  5. Social Security Number 215-34-1523		e (In yrs. ia 67	st birthday) Yrs.	If Under		INGS If Under 2	MILL	S  8. Date of Birt  Month Da  JUN. 22		,	BALT	IMORE (State or Foreign MD
No. Og	D	tor	Usual Residence of Decedent  10a. State 10b. County	IMORE		Town or Lo	cation GS MI	LLS			001122	, 25			nside City Limits
	sath with the s 23s or 28s	Funeral Director	10e. Street and Number 2103 CAVES ROAD	12 Was Dandari	Evor in II C	13.1	10f. Zip		211		poils Voc or No		itizen of Wha	U	SA
9000	4 within 72 hours after death with the Maryland Jiens Then "naturel", or Itama 23a or 28a-f ehow The Madical Examiner must be notified at	by	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces?  1 X Yes 2 □ N If Yes, Give Year or Dates:		1Y	1 🗌 Yes	2[ <b>X</b> No	Specity:	gin? (Spe i, Puerto i	ecify Yes or No Rican, etc.)		Black, \ Specify:	White, etc.	HITE
Maryland 21215-0036	within ene. then "	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4or 5	i+)		dent's Usua kind of wor DO NOT us	rk done du	ırin <b>g</b> most	NER	ng	16b. l	Kind of Busin		y ESTAURAN
ryland	hould be filed id Mental Hygi marked other matic event,	To Be (	17. Father's Name (First, Middle, Last)  LOUIS  19a. Informant's Name/Relationship (Ty)	pe. Print)	ALBAU		ng Address				FANNIE  Route Numbe	***	TOBE		fe)
	nit. Pages 1 and 2 should artment of Heatth and Mer ortent: If Item 27 is merke injury or other traumatic 8.		JUDITH ALBAUGH / 20a. Method of Disposition 1 🔏 Burial 2 □ Cremation 3 □ Re	WIFE	Cei	2103 ace of Dispo	CAVE	S RO	AD -	OWI	NGS MIL	LS,	MD 21 Location - City	117 y or Town,	State
Baltimore,	permit. Pag Department important: eny injury o		4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service License	98	BEIL		2. Name an	d Address	of Facilit	y S0I	3/2006   _ LEVIN ROAD -			S., I	NC.
V	Physician /Medical Examiner	Examiner	23a. Part1. Enter the disease, or complishock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as	s clen a conseque	otic		1.		•	or respiratory ai			Inte Ons	oroximate rival Between set and Death VACS
.O. Box 68760,	The law requires that the death certificate be executed te has been signed by the attending physician and tage 2 should be detached for use as the burial-transit	Physician/Medical Exa	resulting in death) Last	Due to (or as  3c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	of pregnan	cy death 3[	⊒Ectopic pr ] Other (sp						23d. Date o Month	f delivery Day	Year
Δ.	w requires that been signed b should be dete	by	Part II. Other significant conditions con	tributing to death b	ut not resul	ting in the u	nderlying c	ause give	n in Part I.						use of death?
Vital Records,		e Completed	25. Was case referred to medical						26 Place	of Death	24a. Was autor perfo	psy ormed? 2 <b>X</b> N	prio	r to comple	findings available tion of cause of No
Division of Vi	tending Physicath.  tor: After this the funeral dir	Certification; To B	examiner?	28a. Date of Inju (Month, Da	ry y Year)	P/Outpatier 28b. Time o Injury	f 2	28c. Injury Work 1 🗆 Y	r: 4□ Nu	rsing Ho	me 5 Residence 28d. Describe	dence how in	ury occurred		
Divi	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the fune		4 Homicide determined  29a. Certifier 1 Certifying Phys	28e. Place of Inj building, et sician: To the best	c. (Specify)				e, date an		28f. Location ( City or Toward and due to the	wn, Sta	te)		
	To the Ho within 24 t To the Fu completely	Medical	(Check only 2 Medical Examinate) 29b. Signature and life of certifier	ner: On the basis o	f examination at least of the state of the s	on and/or in		i, in my op c. License		th occurr		29d. D	ate signed (A	Aonth, Day,	Year)
	Sta Registi		30. Name and address of person who co Philip Militell 31. Date filed Month, Day, Year)  MAR 1 4 20	10, MD (	int a	imble	Print)  OH:	11 CT.	Lut	herv	:lle,M	any	land	510°	3

			For State	State	of Marylar	d / Dep		f Health	and M	lental Hyg	iene	6	07584
			Registrar  1. Decedent's Name (First, Midd	le, Last)						2. Date of Dea	th	Year	3. Time of Death
	Physicia /Medic		SELMA			AS	HER			MARCH	11, 2006		2:20 P M
	Examin	er	4a. Facility Name (If not institution CHERRYWOOD				4b. City, Tow	n, or Location R F		STOWN	4c. County		TIMORE
	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Ye Months Da	ear If Unde	er 24 Hrs.	8. Date of Birth	Year)		olece (State or Foreign
	Director		218-03-1043	1□M 207 F	8	6 Yrs.	WOTHERS	iys Hours		APR. 12	,1919		MD MD
	land www.		Usual Residence of Decedent  10a. State 10b. County	/	10c. Ci	ly, Town or L	ocation					1	0d. Inside City Limits
	ith the Marylar or 28e-f show s notified at	ctor	MD BA	LTIMORE		OWING	GS MILL:	S					1 □Yes 2 No
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Deparant of Health and Mental Hygiene. Department of Health and Mental Hygiene Important: If item 27 is marked other than *naturel', or items 23e or 28e-f show any injury or other traumetic event, the Medical Examinal must be notified at once.	Funeral Director	10e. Street and Number 12112 HENESON	CADTH			10f. Zip Coo		117	1	l 0g. Citizen of W	hat Cour	ntry? USA
	ms 23	eral	12112 HENESUN	12. Was De	ecedent Ever in U	.S. 13.	Was Decedent			ecify Yes or No- Rican, etc.)	14. Race		can Indian,
9	or ite	Fur	1 Never Married 2 Ma	rried 1 Yes	Forces? s 2(X) No Bive		If Yes, specify (			Rican, etc.)	Specify:	k, White,	etc. WHITE
21215-0036	hours turel',	ed by	3 X Widowed 4 □ Divorce	d Year or	Dates:		dent's Usual Oc				16b. Kind of Bu		
75	n na na	piete	(Specify only highe	nt's Education ast grade complete	d) (1-4or 5+)	(Give	kind of work do DO NOT use re	one during mo stired)	ost of work	ing	100. Killa of Bu	3111033/111	oustry
	filed with Hygiene other the	Completed	Elementary/Secondary (0-12)	College		BANK	MANAGE				BANKING		
and	I be file	Be	17. Father's Name (First, Middle	, Last)		SCHE	TED		her's Name INNIE	e (First, Middle.	Maiden Sumam	θ)	(UNKNOWN)
Maryland	should and Menial marke	ပ	SAMUEL  19a. Informant's Name/Relation	ship (Type, Print)						al Route Numbe	r, City or Town,	State, Zip	
	and 2 lelth a n 27 is er trau		MYRON ASHER /	SON					RTH -	OWINGS	MILLS,	MD 2	21117
ore	of He If item or oth		20a. Method of Disposition 1 X Burial 2 ☐ Cremation	3 □Removal fro			osition (Name o matory or other			Date	20c. Location -		
Baltimore,	ntment rtant: njury		* 4 ☐ Donation 5 ☐ Other ( 21. Signature of Funeral Service	Specify)	BE		LOH CEM 2. Name and Ad				WOODI		
Ba	permit Departr Imports any inj		21. Signature of Funeral Service	Licensee					20F	LEVINS			INC. MD 21208
			23a. Part1. Enter the disease, of shock, or heart failure. Lis	or complications that	t caused the dea							ا واا	Approximate Interval Between
	Physician :	e n	Immediate Cause (Final disease or condition		ROSep	Sis						9	Onset and Death  Well(5
	/Medical Examiner		resulting in death)	Due	o (or as a consec	quence of):							
		-er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that priced exects.	b. Due	o (or as a consec	quence of):	×					-	
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90,	oe exe cian a ourial-t	i Ex	resulting in death) Last	Due	o (or as a consec	quence of):							
09289	taw requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	edicai		d									
Вох (	h certii anding use a	In/Me	IF FEMALE: 23b. Was decedent pregnant		outcome of pregn		⊒Ectopic pregna	2001			23d. Date		*
.O. B	e deat	Physician/Med	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		gnant at time of		Other (specif)				Mor	nth	Day Year
٥	uires that the de n signed by the a ld be detached f		Part II. Other significant condit	ions contributing to	death but not res	sulting in the (	inderlying cause	e given in Par	t I.	23e. Did to	bacco use contr	ibute to t	he cause of death?
Records,	quires n sign uld be	Completed by	Athoroscler	oto Hea	rd fr	50.16				1 🗆 Y	es 2 No	3 Prol	bably 4 Dunknown
900	aw requir as been si 2 should I	piete	Mypertension	,						24a. Was a	an 24b. V	Vere auto	opsy findings available impletion of cause of
E R	The tate has page	Com	(1							perfor	mad? d	leath?	2 No
Vital	siclen: The taw s certificate has t irector, page 2 s	Be	25. Was case referred to medic examiner?	Hospital:				Other -		h (Check only o			
o	Phys ar this aral dii	n: To	1 ☐ Yes 2 🗖 No 27. Manner of Death	11	Inpatient 2 te of Injury onth, Day Year)	28b. Time of		Injury at Work?	Nursing Ho	ome 5 🗌 Resid 28d. Describe h			fy)
ion	Attending Physicien: r death. sctor: After this certifications the funeral director, it	atio	2 - 100100111	tigation	ontn, Day rear)	Injury		Work? 1 ☐ Yes 2 [	□No				
Division	or Atte	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide deter	mined   286. Pla	ice of Injury - At h ilding, etc. <i>(Speci</i>	iome, farm, st	reet, factory, off	fice		28f. Location (S City or Tow		er or Rur	al Route Number,
	Hospitel (4 hours all Funerel D		29a. Certifier 1X Certify	ing Physician: To	the best of my kn	owledge dea	th occurred at th	ne time, date :	and place	and due to the o	ause(s) and ma	nner as s	stated.
	To the Hospitel or Attending Physicien: The within 24 hours after death.  To the Funerel Director: After this certificate his completely filled in by the funeral director, page	Medical		I Examiner: On the									
	To the within 2. To the I complet	Ň	29b. Signature and title of certific	or OLLO	00		29c. Lic	cense numbe	5		29d. Date signed	i (Month,	Day, Year)
	_		· Clant	Jan J	11.7.		7	10 to	57		1 (circh	13	,2006
	6		AGN LETKOW	n who completed ca	ause of death (Ite	m 23a) (Type	) COUR	27#72	05.8	landall.	stow N	13/	) 21133
	Sta		31. Date filed (Mönth, Day, Yea	r) 32	Registrar's Sign	ature	) —		1			i	
	Regist	rar	MAR 1	1 2006 A	Popular 1	K do	and I						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** AIKEN marce 4c. County of Death /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** BALtimure Center VA Madica C DALTIMORE If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1**X** M 2□ F 213-52-4365 Director Usual Residence of Decedent the Maryland 10b, County 10d. Inside City Limits 10c. City, Town or Location 10a State 28a-f show other traumatic event, the Medical Exactinatinual be notified at Balti more 1 Yes 2 No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ŏ 21205 IJSA or Itema 23a 2035 Funeral 12. Was Decedent Ever in U.S. Amed Forces?

1 ★7es 2 □ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Item any injury or other traumatic event the Mental Resident 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 MNo Specify: Specify: Black ò If Yes, Give Year or Dates: 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Sparrows Point College (1-4or 5+) Elementary/Secondary, (0-12) 17-th avade 17. Father's Name (First, Middle, Last) -aborer 18. Mother's Name (First, Middle, Maiden Sumame) M. C. Aiken, Sr. Eva M. Jones 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 6496 Wingate Street Alexandria VA 22312 20b. Place of Disposition (Name cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Murial 2 Cremation 3 Removal from State 03.16-06 Owing Mills, MD Garrison Forest ' 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22 Name and Address of Facility Youghn C. Greene Funeral Services 4005 York Road Baltimore MD 21212 W. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate
Interval Between
Onset and Death
S Month Immediate Cause (Final disease or condition resulting in death) ongestive Heart Failure Physician /Medical Due towr as a consequence of) 3 months **Examiner** Mywardial infarction Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner ed by the attending physician and detached for use as the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 2 1 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Annpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 ② No 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 5 Pending investigation 1 Natural 2 Accident 1 □ Yes 2 □ No 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 | Homicide 29a. Certifier 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier MB AU4176435Z16716

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

ORIGINAL

M D

ION Choose Street Battimer. MD 2124

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MAR 1 4 2006

#### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year 00 WILLIAM THOMAS ANDERSON HARLH 2006 4c. County of Death 4b. City, Town, or Location of Death 4a Fecility Neme (If not institution, give street end number) SING Home 7. Age (In yrs. lest birthday) If Under 1 Year Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Months Days 1 M 2 □ F 225364253 Usuel Residence of Decedent 10b. County 10c. City, Town or Location od. Inside City Limits 10a. State 1 XYes 2 □ No 10g. Citizen of Whet Country? 10e. Street end Number 10f. Zip Code 21 . Race - American Indian, Black, White, etc. ecedent Ever in U,S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Maritel Status Armed Forces? 1 Yes 2 No If Yes, Give 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: 3 ☐ Widowed 4 Divorced Year or Detes: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry College (1-4or 5+) 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Yarian treeman 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 2.1009 20b. Place of Disposition (Neme of cemetery, cremetory or and Court, Hartford, Count 20c. Location - City or Town, State 20a. Method of Disposition Date Buriel 2 Cremetion 3 Removal from State 06 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee leen Approximate Interval Between Onset and Death 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) BONE MARROW WEEK METASTASIS BONE Due to (or as e consequence of) 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown EMENTIA 24b. Were autopsy findings available prior to completion of cause of deeth? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No 26. Place Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28b. Time of 28d. Describe how injury occurred

Examiner Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours effer death.

To the Funeral Director: After this certificate has been signed by the ettending physician end completely filled in by the funeral director, page 2 should be deteched for use as the buriel-transit Division of Vital Records, P.O. Box 68760, Be Completed by Physician/Medical edical Certification: To

**Physician** 

/Medical

Examiner

Funeral Director

Completed by

Be

**Funeral** 

Director

shov

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within nent of Health end Mentel Hygiene.
Int: If item 27 is marked other than

Important: If it any injury or c

Physician

/Medical

Depertment

Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieled events resulting in deeth) Last Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. UREMIA 25. Wes case referred to medical examiner? 1 Yes 2 No 28c. Injury at Work? 27. Menner of Death 28e. Date of Injury (Month, Dey Year) 1 Natural 5 Pending 1 🗌 Yes 2 🗆 No 2 Accident investigetion 6 ☐ Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and menner es stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) end manner stated. (Check only one) 29d. Date signed (Month, Day, Yeer) 29b. Signature and title of certifier

State Registrar Day, Year)

30. Neme end eddress of person

9032717

			For State	State of Marylar			of Health ar	nd Menta		ZUUD	07587
			Registrar  1. Decedent's Name (First, Middle, Las	(t)		Timoato	or Boatin	2. Date	Reg.	No.	3. Time of Death
	Physici		Marion F	156 6 0				Mor		Day Year	6 945AM
	/Medio		4a. Facility Name (If not institution, give	street and number)		4b. City. T	own, or Location of I		J'en	4c. County of De	
	Examir	er	Genesis Perring	Pe co		Com	. 688 -			Raltin	de-,
	Funeral		5. Social Security Number 6\$	ex 7. Age (In yrs.	last birthday)	If Under 1		Hrs. 8. Date	of Birth	9 Bi	irthplace (State or Foreign
	Director		214.26.2002 1	□M 2 <b>X</b> (F)	77 Yrs.	Months	Days Hours	Min. (Mor	or Day, Ye	1928	Country) MP
	P.		Usual Residence of Decedent						1		
	show	_	10a. State 10b. County		ty, Town or Lo						10d. Inside City Limits
	Ba-f a	ct	IFLU NI	4	Battir	rion	٧				Yes 2 No
	or 2	Director	10e. Street and Number	1 10.0.00		10f. Zip (	code	`	10g.	. Citizen of What C	Country?
	ours after death with the Maryland rat', or itema 23a or 28a-f show Examinar must be notified at	Funeral		Avenue			2120	1		USA	
	item Dern	une	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	J.S. 13.	Was Decede If Yes, speci	nt of Hispanic Origir y Cuban, Mexican, F	n? (Specify Yes Puerto Rican, e	tc.)	14. Race - Am Black, Wh	
36	rs aft	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑No If Yes, Give Year or Dates:		1 ☐ Yes 2	No Specify:			Specify: 1	Black
5-0036	filed within 72 hours after Hygiene. ther than "natural", or ite int, ite Wedical Examina		15. Decedent's Ed		16a, Dece	dent's Usual	Occupation		16	b. Kind of Busines	s/industry
215	n "n	plet	(Specify only highest gra	de completed)	(Give	kind of work DO NOT use	done during most o	f working		. 1	0
212	filed with Hygiene. ther the	Completed	Elementary/Secondary (0-12)	College (1,4or 5+)	Sal	18 1	epresenta	utive)		Hecht	Company
Þ	be filed within stal Hygiene. od other than event, the Market han event, the Market han event, the Market han han han han han han han han han han	ВеС	17. Father's Name First, Middle, Last)				18. Mother's	Name (First,	Middle, Mai	iden Surname)	
<u>a</u>	Mental Mental arked o	To E	Howard Johnson	$\mathcal{U}$			Man	NIE	MOV	inoe	
Maryland	s 1 and 2 should be filed withli f Heelth and Mental Hygiene. Item 27 is marked other than other traumatic event, Ite M		19a. Informant's Name/Relationship (	Type, Print)	19b. Maili	ng Address	Street and Number	or Rural Route	Number, C	ity or Town, State,	Zip Code)
	of Heelth item 27 i		Vincent Turner	/301-11-Law	lelele	5. Co	lingsdale	) Road	Bal	more	MD 21234
ore.	ges 1 t of He if iten or oth		20a. Method of Disposition  1 → Burial 2 → Cremation 3 →		Place of Dispo cemetery, crei	osition (Name	e of J er place)	Date	200	c. Location - City o	r Town, State
Ĕ	Pag nent ant: i		`4 □ Donation 5 □ Other (Specify	Hemoval from State	arulan	d Nat	inal 0	3.15.20	106	aurel	MD
3altimore,	permit. Pages Depertment of Important: If I any Injury or once.		21. Signature of Funeral Service Licer	see	2	Name and	Address of Facility	FINE			
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Re	The law isete has be page 2 st	ш							autopsy performed	d? death?	
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of Vital	Physician: this certific ral director,	8	auaminar? 1	Hospital: 1 Inpatient 2	EB/Qutpatier	nt 3□ DOA	Other			e 6 □Other (Sp	ec/fv)
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/	Hospital		29a. Certifier  (Check only 2 Medical Exam	ysician: To the best of my kno	owledge, deat	h occurred a	the time, date and p	place, and due	to the caus	e(s) and manner a	as stated.
	To the Hospital or Attendi within 24 hours efter death. To the Funerel Director: A completely filled in by the fu	Medical	one) 2 medical extili	niner: On the basis of examina and manner stated	ation and/or in	vestigation,	n my opinion, death	occurred at the	time, date	and place, and di	Je to the cause(s)
	To the within 2 To the comple	Σ	29b. Signature and title of certifier			29c.	License number			Date signed (Mor	
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	17		30. Name and address of person who	0 01	m 23a) (Type,	Print)	00.00		,	^	2006 e MD 21239
	l		Nord' Fromber	Wood James		US/ata	Prit Bu	Molney	303	Belting	6 WD 51238
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Signa	A A	rack ;		9			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. U 2. Date of Death 3. Time of Death 1 Decedent's Name (First, Middle, Last) 1240P Physician 2006 March 05 /Medical rocation or C.

Trunder 24 Hrs. 8. Date of Birth
Hours Min. March (24, 1932) 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner GoodSamaritan Bal Birthplace (State or Foreign Country) 5. Social Security Number If Under 1 Year 6. Sex Age (In yrs. last birthday) **Funeral** Days 229-34-257 Usual Residence of Decedent Months 1 M 2 □ F -2577 Yrs Director 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State or 28e-f show traumatic event, the Madical Examiner hust be nutified at Maryland 1 Yes 2 □ No Director IMOI 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2 "natural", or Items 23a 1a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 D No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. ent: If item 27 le marked other then " Elementary/Secondary (0-12) College (1-4or 5+) borer d 18. Mother's Name (First, Middle, Majden Sumame) 17. Father's Name (First, Middle, Last) Be SSea James 01 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) (daughter) O 20b. Place of Disposition (Name of or other Date 20a. Method of Disposition cemetery, crematory or other place) 1 Burial 2 ☐ Cremation permit. Page Department of Importent: If eny Injury or once. 4 ☐ Donation 5 ☐ Other (Specify) 2 Name and Address of Facility 21. Signature of Funeral Service Licensee W. Dorth eral Enter the disease, or complications that caused the property of the cause on each line. List only one cause on each line. Approximate Interval Between dethe death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Onset and Death ATHERUSCLEROTIC fmmediate Cause (Final disease or condition resulting in death) CARDIOVASCUCAR Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physicien and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetaf death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown cate has been signed by page 2 should be detac 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Ď 1 Yes 2 No 3 Probably I I Nown Completed Were autopsy findings available prior to completion of cause of death? autopsy performed certificate No No 1 Tes : After this certification of funeral director, I or Attending Physician: 25. Was case referred to medical 26. Place of Death | Check only one Be examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) 3□ DOA 1 Yes 2 No Impatient 2 ER/Outpatient Certification: To Date of fnjury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1. Natural 5 Pending 1 Tes 2 No investigation 2 Accident Director: / 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Pface of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 \ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one)

within 24 hours after or To the Funeral Direct completely filled in by To the Hospitel

State Registrar

31. Date filed (Month, Day, Year) 2006 4

CEASON

29b. Signature and title of certifier



30. Name and address of person who completed cause of death (ftem 23a) (Type, Print)

29d. Date signed (Month, Day, Year)

2006

		1 - For State Ragistrar	State of Maryland	d / Depa		of He	alth and	Mental Hyg	Reg. No. UUD	07589
Physici /Medio Examir	cal	1. Decedent's Name (First, Middle, Last)  Margaret Jackson  4a. Facility Name (If not institution, give st	reet and number)				ocation of Dea	2. Date of Dea Month March	Day Year 13 2006 4c. County of Dea	1:12 A M
Funeral Director		Carroll County C  5. Social Security Number 220-20-3174  Usual Residence of Decedent	7. Age (In yrs. Ia	est birthday) Yrs.	If Under		f Under 24 Hr Hours Mir			I rthplace (State or Foreign ountry) IMD
5-0036 72 hours after death with the Maryland retural; or Items 23a or 28e-1 show disal Exantiner must be notified at	ector	10a. State 10b. County  MD Baltimore  10e. Street and Number		Town or Lo		Code			10g. Citizen of What C	10d. Inside City Limits 1 Tyes 2 No
s 23a or	Funeral Director	10401 Greentop Rd				210			USA	
036  ours after de  ral', or item  Evancier	d by Fune	11. Marital Status  1 Never Married 2 Married  Wildowed 4 Divorced	Was Decedent Ever in U.S Armed Forces?     □ Yes 2 No     If Yes, Give     Year or Dates:		was Decede If Yes, speci		anic Origin? ( Mexican, Pue Specify:	Specify Yes or No- irto Rican, etc.)	14. Race - Am Black, Wh Specify:	
within sine.	Completed by	15. Decedent's Educi (Specify only highest grade Elementary/Secondary (0-12)	completed) Coflege (1-4or 5+)	(Give life.	DO NOT us	k done dur e retired)	ing most of w		Federal Go Maiden Sumame)	
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Maryla nd 2 should lith and Men 27 is marke		19a. Informant's Name/Relationship (Type Barbara M. Grelli/							r, City or Town, State, ead, MD 2	
Baltimore, M bernit. Pages 1 and 2 Department of Health mportment: If them 27: iny Injury or other tre		20a. Method of Disposition  1X Burial 2 Cremation 3 Re	moval from State	ace of Dispo metery, crei	osition (Nam natory or ot	e of her place)	3/	Date 16/06	20c. Location - City o	r Town, State
Baltimor permit. Pages Department of h Importent: If its any injury or of		21. Signatura Fune of Sangra Licent	man	22	2. Name and	Address	of Facility		Timonium, Dulaney Va nium, MD	
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box 68/60, death certificate be executed  e attending physicien and ind for use as the burial-transit	lical Examiner	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated avents resulting in death) Last  d.	Due to (or as a consequence of the consequence of t	necenter of j.	ess ess	Mig				
death certific death certific e attending p d for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	c. If yes, outcome of pregnar 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de 9 □ Unknown	death 3	Ectopic pre Other (spe				23d. Date of de Month	elivery Day Year
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II KECOTGS, P.O.  The law requires that the cate has been signed by the page 2 should be detache.	Completed							24a. Was autop perfor 1 ☐ Yes	sy prior to	
VISION OT VITAL IN Attending Physician: The order. The ector: After this certificate by the funeral director, pag	ation: To Be	25. Was case referred to medical examiner?  1 Yes 2 No Ho  27. Manner of Death  1 Natural 5 Pending  2 Accident investigation		ER/Outpatier 28b. Time o Injury		Other: Bc. Injury a Work?	4 🗆 Nursing		ne) lence 6 Other (Sp. low injury occurred	ecify)
	Certification:	3 Suicide 4 Homicide 6 Could not be determined	28e. Place of Injury - At hor building, etc. (Specify,	ne, farm, sti	reet, factory,	, office		28f. Location (S City or Tow	Street and Number or F m, State)	Rural Route Number,
To the Hospitel or within 24 hours after To the Funerel Director completely filled in the transmission of transmission of the transmission of the transmission of the transmission of the transmission of transmission	Medical	29a. Certifier 1 Certifying Physic (Check only one) 2 Madical Examin.	cian: To the best of my know ar: On the basis of examinati and manner stated.	vledge, deat on and/or in	h occurred a vestigation,	at the time, in my opin	date and pla- ion, death oc	ce, and due to the courred at the time,	cause(s) and manner a date and place, and du	as stated. ue to the cause(s)
To the within To the Comp	M	29b. Signature and title of certifier	Qnoa	MD	29c.	License n	0 0 5°	4218	29d. Date signed (Mon	on, Day, Year, -06 Jty MD 2115
1,9		30. Name and address of person who con	npleted cause of death (Item		Print)	rale	in hy	dive 1	Nestmin	14 MD 2115
Sta Regist		31. Date filed (Month, Day, Year)	32. Begistrar's Signat	ure	2000	4				

DHMH 17 Rev 1/2001

BENROMORE

MARCARET

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Year Otto Brandau, Jr. March 12, Walter 4:45 P /Medical 2006 4a. Facility Name (If not institution, give street and number) 4b, City, Town, or Location of Death Examiner 4c. County of Death 10535 York Road #310 Cockeysville Baltimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth
(Month, Day, Year)
June 28, 1931 Birthplace (State or Foreign Country) **Funeral** Months Davs Hours 1**∑**M 2□F Yrs. Director 218-26-5613 73 MD Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits ral, or Items 23a or 28a-f shov Examiner repairs 1 ☐ Yes 2 XNo Director MD Baltimore Cockeysville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10535 York Road # 310 Completed by Funeral 21030 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be tiled within 72 hours after c Department of Health and Mental Hygiene. Important: If itam 27 is marked other than "natural", or Item any injury or other traumatic event, the Mental or of the traumatic event, the Mental or other traumatic event, the Mental or or other traumatic event. 1 M Yes 2 No If Yes, Give Year or Dates: 51 1-54 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 X No Specify Specify: White 3 ☐ Widowed 4 ☒ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 4 Sales Automotive 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Walter Otto Brandau, Sr. ၉ Gertrude Cowman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mark W. Brandau/son 41 Arverne Ct. Timonium, MD 21093 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Metro Crematory or other place) 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State March 14, 4 ☐ Donation 5 ☐ Other (Specify) 2006 Baltimore, MD 21. Signature of Fundral Service Lidensee 22. Name and Address of Facility Lemmon Funeral Home of Dulaney Valley, Inc. Michael J. Flagle 10 W. Padonia Road Timonium, MD 21093 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Arteriosc protic Condiovasci **Physician** years /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off. Examiner To the Hospital or Attanding Physician: The law requires that the death certificate be execu Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical d IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Junknown Completed 24a. Was an autopsy performed?
1 ☐ Yes 2 2 100 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA P 1 Yes 2 No 28c. Injury at Work? Manner of Death 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation Diractor: 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 THomicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 1866 March 13,2006 cause of death (Item 23a) (Type, Print) Grimble Hill CT. Latherville, ND 21093 MD 32. Registrar's Signature 31. Date filed (Month, Day, Year) Registrar

**ORIGINAL** 

			1 - For State Registrar	State of Marylar		nt of Health and te of Death	Mental Hygier	4000	07591
	Physici	an	1. Decedent's Name (First, Middle, Last)	Rutler	lui		2. Date of Death	Day 200	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, give	street and number)	#6/2 4b. Cit	y, Town, or Location of Dea		4c. County of Dea	p 10,30"
	Funeral		5. Social Security Number 6. Sec	7. Age (In yrs.	last birthday) If Und Yrs.	er 1 Year   If Under 24 Hrs s Days Hours Min		ar) CEN (S)	thplace (State or Foreign untry)
1	Director		Usual Residence of Decedent  10a, State  10b, County	10c. Ci	ity, Town or Location		- IMAICH 31	1950 14	10d. Inside City Limits
	he Maryl 8a-f sho	ector	Maryland N/A	- J	Baltim	ore			1 X Yes 2 □ No
	ath with t	Funeral Director	5715 Park He	ights Ave	, 612	21215	10g.	Citizen of What Co	7
92	after des	y Fune	11. Marital Status  1 Never Married 2 Married	12 Was Decedent Ever in L Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give	If Yes, sp	edent of Hispanic Origin? (Secrety Cuban, Mexican, Puel 2 No Specify:	Specify Yes or No- to Rican, etc.)	14. Race - Ame Black, White	
21215-0036	72 hours naturel', dicel Exe	eted by	3 Widowed 4 Divorced  15. Decedent's Edu (Specify only highest grade)	Year or Dates:	16a. Decedent's Us	ual Occupation york done during most of wo	rking 16b	. Kind of Business	/Industry
2121	be filed within 72 hours after death with the Maryland lat Hygiene. Id other than "naturel", or Items 23e or 28e-f show event, I're Medical Examinar must be notified at	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	Vacu	uso rotirod) Um Oper	ator !	Sanit	ation
Maryland	should be filt and Mental Hy markad oth umatic even	To Be	Aaron Wesle	v Butler	Sr.	Rosa	me (First, Middle, Maid Lee V	1 . 1	mery
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "naturel", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examinal must be notified at ances.		19a. Informant's Name/Relationship (Ty	de Print) (Sister	19b. Mailing Addre	ss (Street and Number or R LLMA+111a	ural Route Number, Cit Aug. P	y or Town, State,	Zip Code) /
Baltimore,	Pages 1 a nent of Hei int: if Itam iry or othe		20a. Method of Disposition 1 💢 Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)		Place of Disposition (N cemetery, crematory or	ame of other place)	Date 20c.	Location - City or	Town, State
Baltir	permit. F Departme Importar eny injur		21. Signature of Funeral Service Coens	y P.	22. Name JOSEP	and Address of Eacility	Funeral	Home,	2, <del>A</del> ,
÷			23a. Parti. Enter the disease, or compleshook or heart failure. List only or	cations that caused the dea	th. Do not enter the mo	ode of dying, such as cardia	c or respiratory arrest,	Ma. 4	Approximate Interval Between Onset and Death
	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a consec	om yopg	ithy			
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). Box	The law requires that the death certific ate has been signed by the attending p page 2 should be detached for use as	Physician/Me	in the past 12 months?	3c. If yes, outcome of pregn 1 Live birth 2 Fet: 4 Pregnant at time of 6 9 Unknown	al death 3 ☐ Ectopic			23d. Date of de Month	livery Day Year
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tal Re	i <b>ician:</b> The lav certificate has rector, page 2		25. Was case referred to medical			OC Plant of Pa	autopsy performed	? death?	completion of cause of
ž Z	Physician: r this certificatal director,	To Be	examiner? 1 ☐ Yes 2 ÎD No		ER/Outpatient 3 [	OOA Other: 4 Nursing	ath (Check only one) Home 5 Aesidence	6 ☐Other (Spe	icify)
Division of Vital	Attending P ir death. ector: After I by the funera	atlon:	27. Manne of Death  1 Natural 5 Pending  2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how in	ijury occurred	
<u>X</u>	s after de s after de al Direct	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Speci	nome, farm, street, factory)	ory, office	28f. Location (Street City or Town, St		ural Route Number,
	To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Medical (	29a. Certifier (Check only one) 1 Certifying Physical Examination (Check only one) 1 Medical Examination (Check only one)	sician: To the best of my kn- ner: On the basis of examin- and manner stated.	owledge, death occurre ation and/or investigation	d at the time, date and placen, in my opinion, death occ	e, and due to the cause urred at the time, date a	e(s) and manner as and place, and due	s stated. e to the cause(s)
	To the within to the comp	M	29b. Signature and title of certifier	Joual	WD 2	9c. License number	03 29d.	Date signed (Mont	th, Day, Year) Z006
1	7		30. Name and address of person who co		m 23a) (Type, Print)	O178 Belvedeve	Ave. #50	8 Bal	THOSE YOUR ZIZIF
	Sta Registr		31. Date filed (Month, Day, Year)  MAR 1 4 2006	32. Registrar's Sign	ature facility			, it	7.17.18

		. For	, ,		epartment of F			giene	c 0	7500
		1 - State Registrar		(	Certificate of	Death		Reg. No.	0 0	11334
Physic	cian	1. Decedent's Name (First, Middle, La		וז ג בו			2. Date of De			3. Time of Death
/Med	lical	WILHELMINA	RUTH BRAN	DAU	4h City Town o	r Location of Death	MARCH	4c. County	100	, ,
Exam	iner	4a. Facility Name (If not institution, giv	Riversid	0	40. Oity, 10 mil, 0	2	_	1-10	0	1
Funera		5. Social Security Number 6. S	Sex 7. Age (In	yrs. last birth	day) If Under 1 Year	If Under 24 Hrs. Hours Min.				ce (State or Foreign
Directo		220-12-5510	□ M XXF	32 Y	rs. Months Days	Hours Min.	oct.10,	1923	Mar	yland
pu 🔪		Usual Residence of Decedent  10a. State 10b. County	10	c. City, Town	or Location				10d	d. Inside City Limits
Aaryia f sho	ō		ford	,,	Belcamp					1 <b>☐ YesX2X</b> No
the N	rect	10e. Street and Number			10f. Zip Code			10g. Citizen of W	Vhat Country	y?
h with 23e or	al Di	1123 Belcamp	Garth		210	017		US	A	
ems series	Funeral Director	11. Marital Status	12. Was Decedent Eve Armed Forces?	r in U.S.	13. Was Decedent of H If Yes, specify Cub	lispanic Origin? (S an, Mexican, Puert	pecify Yes or No o Rican, etc.)	14. Race Blac	e - American k, White, etc	
<b>CIZIS-UU3O</b> whitin 72 hours after death with the Maryland piene. then "nature!', or Items 23e or 28e-f show the Marilest Ever it set reast te notified at		1 ☐ Never Married 2 ☐ Married	1 ☐ Yes 2 No If Yes, Give Year or Dates:		1□Yes XXNo	Specify:		Specify	Whi	ite
5-0030 72 hours at naturel, or	Completed by	15. Decedent's E	ducation	16a. I	Decedent's Usual Occup	pation		16b. Kind of Bu	ısiness/Indu	stry
within 72 ene. than "na'	plet	(Specify only highest gr Elementary/Secondary (0-12)	ade completed)  College (1-4or 5+)		Give kind of work done life. DO NOT use retire					
	E O	12		CI	aims Aut	horizer		l		Administrat
and ide file ental Hyg	Be	17. Father's Name (First, Middle, Last					•	, Maiden Surnam	18)	
	10	Henry Weissi		106	Mailing Address (Street	1	rine S		State Zin C	ode)
Ta si si si si si si si si si si si si si		19a. Informant's Name/Relationship Beverly Reed-I			05 Brierw					
re, r s 1 and f Healt itam 2		20a. Method of Disposition		20b. Place of	Disposition (Name of crematory or other pla		Date	20c. Location -		
<b>⊙</b> 82=5		XXBurial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci			e National Car	n. March	16 <b>,</b> 2006	Baltimore	Maryla	and
CALLITE TIMIT. Pa partmen portant: y injury	ġ	21. Signature of Funeral Service Lice	nsee		22. Name and Addre	E.	vans Ch	napel O	f Men	nories
2 2 2 2 2 C	ā	Condrae his	M= ladde	7	8800 Har					
		23a. Part1. Enter the disease, or conshock, or heart failure. List only	plications that caused the one cause on each line.	death. Do n	ot enter the mode of dyi	ng, such as cardia	c or respiratory a	ırrest,	li C	Approximate nterval Between Onset and Death
Priysiciai /Medica	-	Immediate Cause (Final disease or condition resulting in death)	- W	cadio		chas				_
Examine			Due to (or s a co	onsequence o	ida cica	rient			1	1 out
,E1013.	Je I	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a co	эпээциепсэ о	11.	U. TUNG				
cuted ord ransit	Examiner	that initiated events	c. Nyo	enfon	si'an					yran
/60, e be executed rsician and e burial-transit	EX	resulting in death) Last	Due to (or a s c	onseq ence o	f):					,
e y e	dicai		d							
. BOX 68 death certifica e attending ph	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of					23d. Dat	te of delivery	/
death death	icial	in the past 12 months?	1 Live birth 2 [		3 ☐ Ectopic pregnanc 5 ☐ Other (specify) _	-y		Mo	inth D	ay Year
Hecords, P.O. The law requires that the de tte has been signed by the z	hys	9 Unknown	9□ Unknown				00.011		75- A-A-A-	
S, Festha		Part II. Other significant conditions	_	_	the underlying cause gr	ven in Part I.		tobacco use cont		cause of death? bly 4 □Unknown
cords, w requires to been signed should be a	Completed	Antein	ers distal	~			1000			10122
I Records, The law requires t sate has been signed page 2 should be	mple						24a. Was auto perf	psy	prior to comp death?	sy findings available pletion of cause of
	e Co	25. Was case referred to medical				26 Place of De	1 ☐ Yes ath (Check only	- 10.	1 ☐ Yes 2	!□ No
f Vital nyaiclan: T nyaiclan: T iis certificat director, pi	0 8	examiner?	Hospital:	2 ER/Out	patient 3 DOA	hor .		idence 6 Oth	er (Specify)	
on of ding Phy h. After this funeral d	n: T	27. Manner of Death  1   Natural 5 □ Pending	28a. Date of Injury (Month, Day Y	28b. T	ime of 28c. Injury	ry at ork?	28d. Describe	how injury occur	red	
Division  or Attending after death. Director: After	catic	2 Accident investigate	on		M 1	]Yes 2□No		(2)		B
DIVISIO  I or Attendi after death.  Director: A	Certification;	3 Suicide 6 Could not 4 Homicide determine		- At home, far Specify)	m, street, factory, office			(Street and Numb own, State)	or or Hurai	Houte Number,
Division of VIta Vota Hoapital or Attending Physician: within 24 hours after death.  To the Funarat Director: After this certific completely filled in by the funeral director.		29a. Certifier 1 Certifying F	hysician: To the best of n	ny knowledge	death occurred at the t	ime, date and plac	e, and due to the	cause(s) and ma	anner as sta	ted.
Hoapita 24 hours Funarat	edical	(Check only 2 Medicel Exe	miner: On the basis of ex and manner stated	amination and	Vor investigation, in my	opinion, death occ	urred at the time	, date and place,	and due to t	the cause(s)
To the within To the comple	Me	29b. Signature and title of certifier	0. /		29c. Licen	se number		29d. Date signe	d (Month, D	ay, Year)
		M CU	Mulu	un	D2	2975		3/12	106	-
0		30. Name and address of person who	1	h (Item 23a) (	Type, Print)	11 0.	0 A	1	21/01	U
-	2404	31. Date filed (Month, Day, Year)	32. Registrar's	Signature	I COLLIVEN	in the	1/1/1	jun a	10/	
Regi	State strar	MAD 1	2005	is	Manage of a					
DHMH 17 Rev	1/2001	MAN 1 4	COUNTY AND AND AND AND AND AND AND AND AND AND	that ships	1 Parties					
				ORIG	GINAL					

WILKELMING

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day 2006 Month **Physician** March 11, 4:25 a M Naomi Broadbent /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Gilchrist Towson If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. NOV. 7, 1913 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 6. Sex **Funeral** 1 □ M 2 🛱 F 92 Marvland 218-46-245B Yrs Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a State 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 X No Director Cockeysville MD Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ö 21030 USA 238 300 International Circle by Funeral filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 Tes 2 2**X** No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ŏ 1 ☐ Yes 2 ☐ No Specify. Specify: White If Yes, Give Year or Dates: 3 □ Widowed 4 □ Divorced "natural', 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) Colfege (1-4or 5+) Own home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be nent of Health and Mental is marked c Scarbrooke Ressie William Walter House 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3 Meadow Mist Ct., Reisterstown, MD J. Streett Broadbent-son Health Itam 27 other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ⊠Burial 2 ☐ Cremation 3 ☐ Removal from State ō Department of Important: If any Injury or once. 3/14/06 Garrison Forest, MD St. Thomas Episcopal 4 Donation 5 Other (Specify) 21. Signature of Funeral Service William G. Dau 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Rd., Towson, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Right Femus **Physician** 2 Weeks disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner nding physician and use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetaf death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 € No 9 ☐ Unknown been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, δ oschanotic Cardiovascular 1 Yes 2 No 3 Probably 4 Nnknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 【No 24a. Was an certificete has t irector, page 2 s autopsy 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Nother (Specify) HOSPICO Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA 1 Yes 2 No this After the 28b. Time of Injury 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death Certification: 1 Natural -a1 1 Yes 2 No within 24 hours after death.

To the Funeral Director: Algorithms of the function of the funct 2. Accident 3 Suicide 28e. Place of Injury: At home, farm, street, factory, office building, etc. (Specify) investigation 28e. Place of Injury: At home, farm, street, factory, office building, etc. (Specify)

HOSPICE

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Zest. Location (Street and Number or Rural Route Number, City or Town, State)

Adv 1 and 1 a 6 Could not be determined filled in by 4 Homicide 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the P 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 18661 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) mble H:11-CT. Lutherville, MD ما 32. Registrar's Signature 31. Date filed (Month, Day, Year) State MAR 1 4 2006 Registrar

DHMH 17 Rev 1/2001

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EVELYN BANKS

		Please Type or Pr				•		.egible.		
		for State OTN State OTN Registrar	•	<i>Pertificate d</i>		nd Mental H	Reg. No.	306	0759	5
		Decedent's Name (First, Middle, Last)		_		2. Date of D	eath Day	Year	3. Time of Dea	ath
Physici /Medic		Virginia Barrows Bland	<u>L</u>			March	12, 2	2006	345	AΜ
Examir		4a. Facility Name (If not institution, give street and number	r)	4b. City, Tow	n, or Location of	Death	4c. C	County of Death		
		Blakehurst Retirement Con			Towson ear   If Under 2	A Hrs O Date of D	i-dl-		imore	
Funeral		5. Social Security Number 6. Sex 7. / 216-46-1661	Age (In yrs. last birtho	Months Da	ays Hours	Min. (Month, L	Day, Year)		place (State or Fo	reign
Director		Usual Residence of Decedent	96			March	23, 19	009 New	Jersey	
yland		10a. State 10b. County	10c. City, Town o	or Location					10d. Inside City L	
B Ma	cto	Maryland Baltimore		Towson			,		1 ☐ Yes 2 §	Ž No
iff the	Director	10e. Street and Number		10f. Zip Co			10g. Citize	en of What Cou	ntry?	
ath w	ral	1055 W. Joppa Road, Apt. 4			204	i=0 (0===# . V== == h		ted Sta		
er de Itams	Funeral	11. Marital Status  12. Was Deceder Armed Force	nt Ever in U.S.	13. Was Decedent If Yes, specify	of Hispanic Orig Cuban, Mexican,	in? (Specify Yes or N Puerto Rican, etc.)	10-	<ol> <li>Race - Americal Black, White,</li> </ol>		
be filed within 72 hours after death with the Maryland tal Hygiene. dother than "natural", or items 23a or 28a-f show avant, I'm Madical Examinations.	þ	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 1 If Yes, Give Year or Date:	3:	1 ☐ Yes 2 🔀	No Specify:		5	Specify: Wh	ite	
72 hours "natural",	etec	15. Decedent's Education (Specify only highest grade completed)	16a. D	ecedent's Usual Or Give kind of work di ife. DO NOT use re	ccupation one during most	of working	16b. Kind	d of Business/In	ndustry	
is should be filed within 72 h and Mental Hygiene. I is marked other than "natural rearms to maturation area."	Completed	Elementary/Secondary (0-12) College (1-4c)	r 5+)	Social			Cit	y Gover	nmont	
Hygie thar thar	e Co	17. Father's Name (First, Middle, Last)		bociai	-	's Name (First, Midd		*	THIETIC	
	o Be	Dr. Arthur Barrows			May	Tabram				
d 2 should the and Mer 7 is marke traumatic	-	19a. Informant's Name/Relationship (Type, Print)	19b. N	Mailing Address (St		r o <i>r Rural Route Nu</i> m	ber, City or	Town, State, Zij	code)	
and 2 ealth a m 27 is		Mrs. Marian White, Daughte	er 440	9 Fox Cha	aser Lan	e, White D	Hall,	MD 2116	1	
of He		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Removal from Sta	cometany	isposition (Name of crematory or other	place)	Date	20c. Loc	ation - City or To	own, State	
Pages ment of l ant: If its ury or o		* 4 ☐ Donation 5 [XOther (Specify)		alley Memor				ium, Mary		
permit. Pages 1 and 2 Department of Health s important: If item 27 is any injury or other tra angings.		21. Signature of Fulleral Service Licensee	1440			Brian T. Ch				
1 00 F 4 0		23a. Part1. Enter the disease, or complications that caus	I113			. 200 Pador		Timonium	n, MD 2109. Approximate	3
		shock, or heart failure. List only one cause on each	line.	1.1.4.4	+ I		arrest,		Interval Betwee Onset and Dea	
Physician /Medical		resulting in death)	gestive as a consequence of)	1700		yopath			271-5	
Examiner	1	15 ch	こへって	Card	no Ma	nopath	4		•	
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executed n and ial-transit	Examin	that initiated events c.	rios cles							
	1 = 1	resulting in death) Last Due to (or	as a consequence of)	):						
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certifii ding I	Physiclan/Medical	IF FEMALE: 23c. If yes, outcome	ne of pregnancy				23	3d. Date of deliv	erv	
atter	clar		2 Fetal death at time of death	3 ☐Ectopic pregn 5 ☐ Other (specif				Month	Day Year	f
the c	hysi	9 ☐ Unknown 9 ☐ Unknown	1							
vician: The law requires that the descriptions. The law requires that the descriptions of the law requires that the descriptions are sold to the rector, page 2 should be detached.	by P	Part II. Other significant conditions contributing to deat	but not resulting in t	he underlying caus	e given in Part I.	23e. Dio	d tobacco us		the cause of deat	
aquire en siç buld b	ed					1	Yes 2□	]No 3∏Pro	bably 4 🗷 Onki	nown
law re as be 2 sho	ompleted					24a. Wa	opsy		opsy findings ava	
The The ate h	Com					1 ☐ Yes	formed? 2 No	death? 1 ☐ Yes	2 No	
cian: ertific ector,	Be	25. Was case referred to medical examiner?				of Death (Check onl)	/ one)			
Physician: The lave this certificate has ral director, page 2	2	1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpo			Other: 4 Nui	rsing Home 5 Re			fy)	_
ding F h. After funera	lon	1 Natural 5 Pending (Month,	Day Year) 200. This		Work? 1 ☐ Yes 2 ☐ I		o now injury	00001104		
for Attanding after death.  Director: After lin by the fune	ertification;	3 Suicide 6 Could not be determined 28e. Place of	Injury - At home, farn			28f. Location		Number or Rur	al Route Number	
d in b	erti	4 Homicide determined building,	etc. (Specify)			City or I	own, State)			
To the Hospital or Attanding Physician: The law requires that the death certificate be within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physicis completely filled in by the funeral director, page 2 should be detached for use as the bu	icalC	29a. Certifier (Check only 2 Medicel Exeminer: On the basis	of examination and/	death occurred at to for investigation, in	he time, date and my opinion, deat	d place, and due to the	e cause(s) a e, date and p	and manner as a	stated. to the cause(s)	
thin 2 tha	Medical	one) and manner  29b. Signature and title of certifier	sidieu.		cense number			signed (Month,		
± 3 ± 8		Milli w M			DY	2129	M	with	13, 20	04
12		30. Name and address of person who completed cause of		ype, Print)	01 1	2129 Chades	R	aldre	we d	12)
St	ate	William C.	strar's Signature	و والا	- ( -		۶.			-
Regist	rar	THEFT IS GOOD AND IN	W 545 1800	ACTA AND ASSESSMENT						

Registrar

State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician ROBERT WAYNE BEARES MARCH 11, 2006 9:40 /Medical 4c. County of Death Examiner 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death CARROLL HOSPITAL CENTER WESTMINSTER CARROLL If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign
Country) **Funeral** Days Hours 1₩ M 2□F 213-46-2882 Yrs. Director 61 12/29/1944 MARYLAND Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Modical Examinar must be notified at 1 Yes 2 No MD CARROLL WESTMINSTER Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 520 LACOSTA CIRCLE, T2 21158 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 230 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 X Never Married 2 ☐ Married Saltimore, Maryland 21215-0036 1 ☐ Yes 💥 No Specify: 2 Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b Kind of Business/Industry (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) BOOK KEEPER FLOWER SHOP 12 8 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be and Mental I HOWARD EDMUND BEARES MARGARET MARIE MADER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Item 27 THOMAS E. BEARES -BROTHER 319 MILLWRIGHT CIRCLE, ABINGDON, MD 21009 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 Iment of P 1,□ Burial 2 🗷 Cremation 3 □ Removal from State Depertment of Important: If eny injury or once. Winfield, MD 3-13-06 □Donation 5 Other (Specify) Burrier-Queen Service Licensee 22. Name and Address of Facility FLETCHER FUNERAL HOME 254 E. MAIN ST., WESTMINSTER, MD. 21157 the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, eart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Nyocardia **Physician** 5 minute disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner ettending physicien end for use as the burial-transit Due to (or as a consequence of): certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day 4 Pregnant at time of death 5 Other (specify) P.O. 1 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. ۵ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 certificate has 1 ☐ Yes 22 No Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death | Check only one examiner' Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 FNOutpatient 3 DOA 1 Yes 2 No this 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier completely within 2 29b. Signature and title of certifier D26385 Name and address of person who completed cause of death (Item 23a) (Typer Print) form and Tolks term MD 218 Washing for Height 31. Date filed (Month, Day, Year) \$2. Registrar's Signature State 4 2006 Registrar

	-	Stata Registrar		Cert	tificate o	f Death	R	ag. No.	UD	UIUJ
		. Decedent's Name (First, Middle, Last)					2. Date of Dea Month	th Day	Year	3. Time of Death
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/Medic		ia. Facility Name (If not institution, give sti			4b. City, Towr	, or Location of Death		4c. Cour	ity of Death	
Examino uneral	31	5. Social Security Number 6. Sex		ast birthday)_ Yrs.	If Under 1 Ye		8. Date of Birth	1	9. Birth	place (State or Fore
rector		08-20-2876	17				JL1 . L7	,1520		
2	-	Usual Residence of Decedent 10a. State 10b. County	10c. City	. Town or Loc	ation					10d. Inside City Lim
ehow m t			,	DALT	IMORE				1	1 <b>∑</b> Yes 2 🗀
1	5	MD N/A		DALI					43471 4 0	-12
or 2	Director	10e. Street and Number			10f. Zip Cod			10g. Citizen o	or what Cou	
30	<u>=</u>	2901 FALLSTAFF RO	AD #504			21209				USA
d other than "naturel", or Iteme 23e or 28s-f ehov event, the Medical Examinet must be nutified at	by Fur	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	2. Was Decedent Ever in U.: Armed Forces? 1	1f	Vas Decedent Yes, specify C ☐ Yes 2 💢	of Hispanic Origin? (Sp Buban, Mexican, Puerto No <i>Specify:</i>	ecity Yes or No Rican, etc.)		lace - Amer llack, White cify:	
at a	ed	15. Decedent's Educ		16a. Deced	ent's Usual Oc	cupation ne during most of work	vina	16b. Kind of	Business/l	ndustry
- 1	Completed	(Specify only highest grade		life. D	OO NOT use re	tired)	ung			
1	Ĕ	Elementary/Secondary (0-12)	College (1-4or 5+)	OWNER				REAL	<b>ESTAT</b>	E
불분		17. Father's Name (First, Middle, Last)				18. Mother's Nam	e (First, Middle,	Maiden Sun	ame)	
D O	Be			BARE	R	EDITH				FISHMAN
	은	BENJAMIN								
7 is mark traumatic		19a. Informant's Name/Relationship (Typ				eet and Number or Ru				
N -		SYBIL BARER / WI	FE	2901	FALLS	raff Road #	15U4 - B			
Item 2 other		20a. Method of Disposition		lace of Dispos	sition (Name o		Date	20c. Location	on · City or	Town, State
= 0		1 🕅 Burial 2 ☐ Cremation 3 🕅 Re 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	*	CEMETI		3/2006	PINELA	WN. N	EW YORK
tan l										
Important: If It eny injury or o		21. Signature of Funeral Sarvice License  23a. Part1. Enter the disease, or complice	Cietter	8	900 RE	ISTERSTOWN		PIKESV		
/sician ledical aminer	Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, Tany, leading to an analysis cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conseq	uence of):		Henra	. es e			
icien	CG									
d by the attending physicien and letached for use as the burial-transit	Physician/Medical	in the past 12 months?  1 Yes 2 No 9 Unknown	3c. If yes, outcome of pregns 1 Live birth 2 Feta 4 Pregnant at time of c	al death 3 death 5	Ectopic pregr	y)	23e. Did		Date of del	Day Year
by the attending ached for use as	by Physician/Me	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No	1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d 9 ☐ Unknown	al death 3 death 5	Other (specif	y)		tobacco use	Month	Day Year
been signed by the attending should be detached for use as	by Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d 9 ☐ Unknown	al death 3 death 5	Other (specif	y)	1 a	tobacco use o	Month  contribute to  3 Pr  4b. Were au	Day Year the cause of death
been signed by the attending I should be detached for use as	by Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d 9 ☐ Unknown	al death 3 death 5	Other (specif	y)	1 a	tobacco use o	Month contribute to	Day Year  the cause of death  tobably 4 Unkr  utopsy findings avai  completion of cause
been signed by the attending should be detached for use as	Completed by Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  Part II. Other significant conditions cor	1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d 9 ☐ Unknown	al death 3 death 5	Other (specif	e given in Part I.  26. Place of De	24a. Was auto perfu 1 Yes	Yes 2 N s an 2 promed? 2 No one)	Month  contribute to  3  Pr  4b. Were au prior to death? 1  Yes	Day Year  the cause of death robably 4 Dunkr  utopsy findings avaicompletion of causi
been signed by the attending should be detached for use as	To Be Completed by Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 \( \superscript{\text{Yes}} \) 2 \( \superscript{\text{No}} \) 9 \( \superscript{\text{Unknown}} \) Part II. Other significant conditions con  25. Was case referred to medical examiner? 1 \( \superscript{\text{Yes}} \) 3 \( \superscript{\text{No}} \) 27. Manner of Death	1 Live birth 2 Feta 4 Pregnant at time of d 9 Unknown  hthibuting to death but not res  Hospital: Inpatient 2 2	al death 3 death 5 death 5 death 5 death 5 death 5 death 5 death 5 death 6 dea	Other (specifinderlying cause)	e given in Part I.  26. Place of De.  Other: 4 □ Nursing H	24a. Was auto perfu 1 Yes	Yes 2 No 2 No one)	Month  contribute to  3  Pr  4b. Were au prior to death? 1 Yes	Day Year  the cause of death  tobably 4 □Unkr  utopsy findings avai  completion of cause
been signed by the attending should be detached for use as	To Be Completed by Physician/Me	23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown  Part II. Other significant conditions con  25. Was case referred to medical examiner? 1   Yes 2   No    27. Manner of Death 1   Natural 5   Pending	1 Live birth 2 Feta 4 Pregnant at time of d 9 Unknown  htributing to death but not res  Hospital:	al death 3 death 5 death 5 death 5 death 5 death 5 death 5 death 5 death 6 dea	Other (specifinderlying cause)	e given in Part I.  26. Place of De	24a. Was autopent 1 yes ath (Check only thome 5 Res	Yes 2 No 2 No one)	Month  contribute to  3  Pr  4b. Were au prior to death? 1 Yes	Day Year  the cause of death robably 4 □Unkn  utopsy findings avai completion of cause
been signed by the attending should be detached for use as	To Be Completed by Physician/Me	23b. Was decedent pregnant in the past 12 months?  1	1 Live birth 2 Feta 4 Pregnant at time of d 9 Unknown  hthibuting to death but not res  Hospital: Inpatient 2 2	al death 3 death 5 dea	Other (specifical and and and and and and and and and and	26. Place of De:  Other: 4 □ Nursing H Injury at Work? 1 □ Yes 2 □ No	24a. Was auto per 1 Describe 28f. Location	Yes 2 N san 2 psy 2 No one) idence 6 how injury of	Month  contribute to  3  Pr  4b. Were at prior to death? 1  Yes	Day Year  the cause of death robably 4 □Unkn  utopsy findings avail completion of cause  2 ☑ No
4 hours effer death. Funerel Director: Affer this certificate hes been signed by the attending: ely filled in by the funeral director, page 2 should be detached for use as	Certification; To Be Completed by Physician/Me	23b. Was decedent pregnant in the past 12 months?  1	1 Live birth 2 Feta 4 Pregnant at time of d 9 Unknown  Inhibiting to death but not res  Hospital: Inpatient 2 28a. Date of Injury (Month, Day Year)  28e. Place of Injury - At h	al death 3 death 5 dea	nderlying cause  nt 3 DOA  f 28c.  M  reet, factory, o	26. Place of De  26. Place of De  Other: 4 \sum Nursing H  Injury at  Work?  1 \sum Yes 2 \sum No  ffice	24a. Was auto perf 1 Yes ath (Check only thome 5 Res 28d. Describe 28f. Location City or To	Yes 22N s an 2 ppsy ormed? 22No one) idence 6 how injury or (Street and N own, State)	Month  contribute to  do 3  Pi  4b. Were au prior to death? 1  Yes  Courred	Day Year  to the cause of death robably 4 Dunkn  utopsy findings avai completion of cause  22 No
4 hours effer death. Funerel Director: Affer this certificate hes been signed by the attending: ely filled in by the funeral director, page 2 should be detached for use as	To Be Completed by Physician/Me	23b. Was decedent pregnant in the past 12 months?  1   Yes 2   No 9   Unknown  Part II. Other significant conditions con  25. Was case referred to medical examiner?  1   Yes 2   No   House   No   House   No   House    27. Manner of Death   Pending   Investigation   3   Suicide   Accident   Homicide   Gould not be determined    29a. Certifier   Check only   2   Medical Examiner	1 Live birth 2 Feta 4 Pregnant at time of o 9 Unknown  Inhibiting to death but not res  Hospital: 28a. Date of Injury (Month, Day Year)  28e. Place of Injury - At h building, etc. (Speci	al death 3 death 5 dea	nderlying cause  nt 3 DOA  of 28c.  M  reet, factory, o	26. Place of De  26. Place of De  Other: 4 \sum Nursing H  Injury at  Work?  1 \sum Yes 2 \sum No  ffice	24a. Was auto perf 1 Yes ath (Check only thome 5 Res 28d. Describe 28f. Location City or To	Yes 2 No s an 2 psy ormed? 22 No one) idence 6 how injury or (Street and Nown, State) e cause(s) an date and pla	Month  contribute to  a 3 Pr  4b. Were au prior to death? 1 Yes  Courred	Day Year  the cause of death robably 4 □Unkn  utopsy findings avail completion of cause  22 No  ural Route Number,
4 hours effer death. Funerel Director: Affer this certificate hes been signed by the attending: ely filled in by the funeral director, page 2 should be detached for use as	edical Certification; To Be Completed by Physician/Me	23b. Was decedent pregnant in the past 12 months?  1	1 Live birth 2 Feta 4 Pregnant at time of o 9 Unknown  Inhibiting to death but not res  Hospital: 28a. Date of Injury (Month, Day Year)  28e. Place of Injury - At h building, etc. (Speci	al death 3 death 5 dea	nderlying cause  nt 3 DOA  of 28c.  M  reet, factory, o  th occurred at 1 reestigation, in  29c. L	26. Place of De.  26. Place of De.  Other: 4 \subseteq Nursing H Injury at Work? 1 \subseteq Yes 2 \subseteq No  Iffice  the time, date and place my opinion, death occidense number	24a. Was auto perf 1 Yes ath (Check only thome 5 Res 28d. Describe 28f. Location City or To	Yes 2 No s an 2 psy ormed? 22 No one) idence 6 how injury or (Street and Nown, State) e cause(s) an date and pla	Month  contribute to  a 3 Pr  4b. Were au prior to death? 1 Yes  Courred	Day Year  the cause of death robably 4 □Unkn  utopsy findings avail completion of cause  avail completion of cause  corfy)  ural Route Number,  s stated, e to the cause(s)  th, Day, Year)
within 24 hours effer deam.  To the Funerel Director: Affer this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	edical Certification; To Be Completed by Physician/Me	23b. Was decedent pregnant in the past 12 months?  1   Yes   2   No   9   Unknown  Part II. Other significant conditions cor  25. Was case referred to medical examiner?  1   Yes   2   No   1   1   1   1   1   1   1   1   1	1 Live birth 2 Feta 4 Pregnant at time of d 9 Unknown  Intributing to death but not res  1 28a. Date of Injury (Month, Day Year)  28e. Place of Injury - At h building, etc. (Special of the set)  28ician: To the best of my kn inar: On the basis of examin and manner stated.	al death 3 death 5 dea	nderlying cause  nt 3 DOA  t 28c.  M reet, factory, o  th occurred at 1  restigation, in	26. Place of De.  26. Place of De.  Other: 4 \subseteq Nursing H Injury at Work? 1 \subseteq Yes 2 \subseteq No  Iffice  the time, date and place my opinion, death occ	24a. Was auto perf 1 Yes ath (Check only thome 5 Res 28d. Describe 28f. Location City or To	Yes 2 No s an 2 psy ormed? 22 No one) idence 6 how injury or (Street and Nown, State) e cause(s) an date and pla	Month  contribute to  a 3 Pr  4b. Were au prior to death? 1 Yes  Courred	Day Year  the cause of death robably 4 □Unkn  utopsy findings avai completion of cause  2 → No  vcify)  ural Route Number,  s stated. e to the cause(s)
been signed by the attending should be detached for use as	edical Certification; To Be Completed by Physician/Me	23b. Was decedent pregnant in the past 12 months?  1	dospital:  28a. Date of Injury (Month, Day Year)  28b. Place of Injury (Action, Section)  28c. Place of Injury - At he building, etc. (Special)  28c. Place of Injury - At he building, etc. (Special)	al death 3 death 5 dea	nderlying cause  nt 3 DOA  t 28c.  M reet, factory, o  th occurred at 1  restigation, in	26. Place of De.  26. Place of De.  Other: 4 \subseteq Nursing H Injury at Work? 1 \subseteq Yes 2 \subseteq No  Iffice  the time, date and place my opinion, death occidense number	24a. Was auto perf 1 Yes ath (Check only thome 5 Res 28d. Describe 28f. Location City or To	Yes 2 No s an 2 psy ormed? 22 No one) idence 6 how injury or (Street and Nown, State) e cause(s) an date and pla	Month  contribute to  3 Pr  4b. Were at prior to death? 1 Yes  Courred  Cou	Day Year  the cause of death robably 4 Unkn  utopsy findings avai completion of cause  22 No  crify)  ural Route Number, s stated, e to the cause(s)

			For State Registrar	State of Maryla		partment of F certificate of i		Mental Hy	/giene	1000	07598
	Physici		1. Decedent's Name (First, Middle, Las Leslie Pataudi Bri					2. Date of D Month March	Day	y Year 2006	3. Time of Death 9:33 PM
,	/Medic Examin		4a. Facifity Name (If not institution, give Holy Cross Hospita	street and number)			Location of Death			County of Death Montgom	
	Funeral Director		5. Social Security Number 6. Se	7. Age (In yrs	60 Yrs	ay) If Under 1 Year Months Days	ff Under 24 Hrs. Hours Min.	8. Date of B (Month, D Februa	irth bay, Year) ry 7,	9. Birthr	place (State or Foreign http) Uyana
	Maryland a-f show	ctor	10a. State 10b. County Maryland Montgome		Silver	Spring				1	10d. Inside City Limits 1 ☐ Yes 2 X No
	h with the 23a or 28 st be no	Funeral Director	10e. Street and Number 3409 Robey Terrace	e, Apt. 302		10f. Zip Code 20904				izen of What Coul	•
0000	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Deperment of Heath and Mental Hygiene. Important: If time 27 is marked other than "natural", or items 23a or 28a-f show sny injury or other traumatic svent, the Modical Examinar most be notified at once.	by Funer	11. Maritaf Status  1 ☐ Never Married 2 ☒ Married  3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in Armed Forces?  1 ☐ Yes 2 No ff Yes, Give Year or Dates:	U.S. 1	<ol> <li>Was Decedent of H   If Yes, specify Cuba   1 ☐ Yes 2 No</li> </ol>	ispanic Origin? (S in, Mexican, Puert Specify:	pecify Yes or No Rican, etc.)	0-	14. Race - Americ Black, White, Specify:Indo	
N-6171	within 72 hounde.	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)	ucation de completed) College (1-4or 5+)	(G lif	ecedent's Usual Occup live kind of work done e. DO NOT use retired ales/busine	during most of wor f)	king		ind of Business/In	dustry
yland z	lbe filed value Hygie	Be	17. Father's Name (First, Middle, Last) Brijbassy Samaroo	4	Se	ares/busine	18. Mother's Nar Rosalir		e, Maiden	Omputer Sumame)	
Maryi	nd 2 should Ith and Mei 27 is mark r traumatio	ဥ	19a. Informant's Name/Relationship (7 Vijay Brijbasi/bro			ailing Address (Street  Evesham	and Number or Ru		ber, City o		Code)
baltimore,	Pages 1 ar nent of Hea int: if itsm: iry or other		20a. Method of Disposition  1 XBurial 2 Cremation 3 4 Donation 5 Other (Specify	20b.	cemetery, o	sposition (Name of crematory or other place idge Cemete	· 1	Date 9, 2006		ocation - City or To esville,	
Dall	permit. Depertrice Imports any inject.		21. Signature of Funeral Service Licen	chell I		22. Name and Addre Mitche 6500	s of Facility 211-Wiede York Rd.	efeld Fu Balti	inera Imore	1 Home, MD 21	Inc. 212
, 1	Physician /Medical		23a. Part. Enter the disease, or compensor, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a Atheroscle	rotic	enter the mode of dyin	g, such as cardiad	or respiratory	arrest,		Approximate Interval Between Onset and Death
	Examiner	i Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Hypertensi Due to (or as a conse Due to (or as a conse Diabetes Due to (or as a conse	On equence of):				18		
.O. BOX 66/6U,	death certi e attending ad for use a	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. ff yes, outcome of pregrup 1 Live birth 2 Fe 4 Pregnant at time of 9 Unknown	tal death	3 □Ectopic pregnancy 5 □ Other (specify) □	,			23d. Date of defive	ery Day Year
ecords, r	law requires that the as been signed by th 2 should be detache	þ	Part II. Other significant conditions of	ontributing to death but not re	sulting in th	e underlying cause giv	en in Part I.		tobacco (		he cause of death?
ב	: The law re icete has bei r, page 2 sho	Completed						24a. Wa aut per 1 ☐ Yes	opsy formed?	prior to co death?	ppsy findings available mpletion of cause of 2 No
l Vital	nysiciar nis certif directo	To Be	25. Was case referred to medical examiner? 1∭Yes 2 □ No	Hospital: 1 ☐ Inpatient 2 [	☐ ER/Outpa	itient 3X DOA Oth	er: 4 ☐ Nursing H			6 ☐Other (Specif	(y)
Division of	To the Hospital or Attending Physician: within 24 hours effer death. To the Funeral Director. After this certifical completely filled in by the funeral director.	Certification:	27. Manner of Death  1 XNatural 5 Pending investigation		28b. Tim Inju	ry Wor	yat k? Yes 2 ∐No	28d. Describe	how inju	ry occurred	
	ital or Att urs efter d rai Diract lled in by t	Certific	3 ☐ Suicide 6 ☐ Could not be determined	building, etc. (Spec	city)			City or T	own, State		
	na Hosp n 24 hou na Fune detely fil	edicai	29a. Certifier 1 ☐ Certifying Ph (Check only one) 1 ☐ Certifying Ph 2 Medical Exam	ysician: To the best of my kr niner: On the basis of examinand manner stated.	nowledge, d nation and/o	eath occurred at the tir r investigation, in my o	ne, date and place pinion, death occu	, and due to the tred at the time	e cause(s) e, date and	) and manner as s d pface, and due to	tated. the cause(s)
	To the company	Σ	29b. Signature and title of certifier	usko May	, ma	29c. Licens D519				te signed (Month.	
	6		30. Name and address of person who of Patricia Tomsko N	av. MD 11119	Rock	ville Pike	, G-100	Rockv			
¥	Sta Registr		31. Date filed (Month, Day, Year)  MAR 1 4 2005	32. Registrar's Sign	natura	Ser P					

	State of Maryland / Department of Health and Certificate of Death	-	leg. No. 0 0	6 07599
Dhysisian	1. Decedent's Name (First, Middle, Last)	2. Date of Dea Month	Dey	3. Time of Death
Physician /Medical	DOROTHY BRYANT	MARCH	6, 2006	9:13p
Examiner	44 Technity Halife (if Not Visitability, give sit one visitability)	Location of Deeth	4c. County	
	29 S. ELLAMONT ST. BALTIMO		N/A	
uneral	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Deys Hours Min	. (Month, Dey	, Year)	Birthplace (Stete or Fore Country)
rector	248-56-5223 67 113	10-31-	1938	SOUTH CAROL
-	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location			10d. Inside City Lim
trein 21 is merked ones than hautral, or nems 23s or 28st show other traumetic event, the Medical Examiner must be notified at To Be Completed by Funeral Director				1 X Yes 2 □ I
Director	MD. N/A BALTIMORE		10g. Citizen of V	What Country?
조	10e. Street end Number 10f. Zip Code			anet Country i
a is	29 S. ELLAMONT ST. 21229	0	USA	e - American Indian,
iner must Funeral	11. Marital Status  12. Was Decedent Ever in U,S. Armed Forces?  13. Was Decedent of Hispenic Origin? (if Yes, specify Cuban, Mexican, Pue	rto Rican, etc.)	Blac	k, White, etc.
Ϋ́F	1 □ Never Married 2 ☑ Married 1 □ Yes 2 ☑ No If Yes, Give 1 □ Yes 2 ☑ No Specify: 3 □ Widowed 4 □ Divorced Year or Dates:		Specify	BLACK
Q Q			10h Kind of Du	- in a second second
Completed by	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of wo	orking	16b. Kind of Bu PETERSO	N, HOWELL &
E	Elementary/Secondary (0-12)  -12-  College (1-4or 5+)  LABORER			EATHER
ပိ		ame (First, Middle,	Maiden Surnam	<b>a</b> )
Be		ETER SING		-/
2			_	State Zin Carla)
į	19a. Informant's Name/Relationship (Type, Print)  WILLIAM BRYANT(HUSBAND)  19b. Mailing Address (Street and Number or F  29 S. ELLAMONT ST. B		-	
		Date		City or Town, State
	1 M Burial 2 Tromation 2 Demonstrate cemetery, crematory or other place)			•
i	4 Donation & Other (Specify)			MORE, MARYLA
once.	21. Signature of Funeral Service Licens 20 NATHAN D. HTBNER2. Name and Address of Facility FII			
5 8	1721-27 N. MONROE	ST. BALT	IMORE,	MARYLAND 212.
	23a. Part1. Efter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardio shock/gr heart failure. List only one cause on each line.	ac or respiretory ar	rest,	Approximate Interval Between
an	shock/or heart failure. List only one cause on each line.			Onset and Death
al	Immediate Cause (Final			3 mouth
er	Immediate Cause (Final disease or condition resulting in death)  a. Luus Cazumoma -			1
ĕ 🚾	540 to (01 40 4 00 100 40 00 1).			:
Examiner	b			
X	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury			1
edical	that initieted events			
	resulting in death) Last			
for use es cian/Me	d	***		1
icia	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23h Did t	nhacco use cor	ntribute to the cause of de
y Physician/M	Fall II. Other significant conditions continuously to death but not resoluted in the underlying cause given in all in		/es 2□ No	3 XProbably 4 ☐ Unkr
4			65 2 110	Tobasi, 4 dina
d by F		24a. Was	an autopsy	24b. Were autopsy findin
Completed		perfo	med?	available prior to completion of cause of death?
Сошр		(8)113	~	
Ŝ		167	38 2 NO	1 ☐ Yes 2 ☐ No
Be	examiner?	eath (Check only o	ne)	
To Be C		Home 5 S esid		
Certification:	27. Menner of Death  28a. Date of Injury  28b. Time of Injury  28c. Injury at Work?  28c. Injury at Work?	28d. Describe h	low injury occuri	red
cati	2 Accident investigation M 1 Yes 2 No			
E	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	281. Location (S City or Tow	itreet and Numb n, State)	er or Rural Route Number,
edicai	29a. Certifier (Check only addical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred.			
8	one) and manner stated.			
Σ	29b. Signature and title of certifier 29c. License number	_	_	d (Month, Day, Yeer)
	Byg Tourne D2625	6	3/8	106
	30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)  BICH T. DVONG-MD 724 MH DEN CHURE US  31. Date filed (Month, Day, Year)  MAR 1 4 2006  32. Registrer's Signature		4	
	BICH T. DUONG, MO 724 MAIDEN CHAIRE US	THE B	MITIM &	Z= MO 2/2
State	31. Date filed (Month, Day, Year) 32 Registrer's Signature			
istrar	MAR 1 4 2006 Amar A			

			For State Registrar	State of Ma		/ Depa		t of H	ealth a			_	6	07600
ı	Physici		1. Decedent's Name (First, Middle, L	BUTLER							2. Date of Dear Month MARCH	Day	Year 5	3. Time of Death 7:15p M
	/Medio Examin		4a. Facility Name (If not institution, g	ive street and number)					Location o	f Death		4c. Count	y of Death	
-	Funeral		BON SECOURS HC 5. Social Security Number 6.	Sex 7. Age	(In yrs. last	birthday)	If Under		If Under 2	24 Hrs.	8. Date of Birth		N/A 9. Bjrth	place (State or Foreign
	Director		223-48-8947	1 □ M 2 □ F	68	Yrs.	Months	Days	Hours	Min.	8. Date of Birth (Month, Day, 12–26–	1937	VIR	GINIA
	yland		Usual Residence of Decedent  10a. State 10b. County		10c. City, T	own or Lo	ocation							10d. Inside City Limits
	the Marks	ector	MD • N/A	7	BA	LTIMO		Cada			1	On Citizen of	M/hat Cav	1 Tyes 2 No
	With t	al Dir	827 N. ARLING	TON ST.			10f. Zip	212	17			0g. Citizen of USA		intry :
350	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or Items 23a or 28a-f show ther the Medical Examiner must be notified at	by Funeral Director	11. Marital Status  1 □ Never Married 2 ☒ Married  3 □ Widowed 4 □ Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☑ N If Yes, Give Year or Dates:			Was Deced If Yes, spec		spanic Orig n, Mexican Specify:	gin? (Spe , Puerto F	cify Yes or No- Rican, etc.)		ick, White	ican Indian, , etc.
215-0030	72 hou	eted	15. Decedent's (Specify only highest of	Education grade completed)	1	6a. Deced	dent's Usua kind of wor DO NOT us	il Occupa rk done d	ition uring most	of working	lg	16b. Kind of E		
7 7	d within 72 ho piene. r than "natur the Medical	Completed	Elementary/Secondary (0-12) -8-	College (1-4or 5	+)		DO NOT US JSEKEI					DOMES	STIC	
<u> </u>	m - 0 2	Be	17. Father's Name (First, Middle, La								(First, Middle, i		me)	
ızyıa	should nd Men marke matic	ို	SOLOMON HARRIS  19a. Informant's Name/Relationship		Τ.	19b. Mailir	ng Address	(Street a			E JORDA		, State, Zi	ip Code)
, Mal	and 2 salth ar n 27 is ser trau		WILLIE BUTLER			827	7 N. A	ARLI		ST.	BALTIM	DRE, M	ARYLA	ND 21217
ore	nit. Pages 1 and 2 should be autment of Health and Menta ortant: if Item 27 is marked injury or other traumatic ev. 8.		20a. Method of Disposition  1 X Burial 2 Cremation 3		ceme	etery, crer	sition (Nam matory or of CEME	ther place				20c. Location		own, State  MARYLAND
Baltimore,	permit. Pa Departmen important: any injury once.		4 □ Donation 5 □ Other (Special Signature of Fundamental Service Lie			IBNE	Name and	d Addres	s of Facilit	y PHI	LLIPS F	UNERAL	HOME	
6		Sto	23a. Party Enter the disease, or co show, or heart failure. List on	mplications that caused by one cause on each lin	the death. [	Do not ent	er the mode	e of dying	g, such as	cardiac o	respiratory arr	est,		Approximate Interval Between Onset and Death
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7	uted d ansit	Examiner	Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events	Due to lor as	a consacioen	noei iotje								
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N II	Physician: r this certific ral director.	Be	25. Was case referred to medical examiner?	Hospital:	nt 2DER	Outpatier	3 00	Othe	100		(Check only on		har (Spag	(6.1)
on or	ng fte fte	ation: To	27. Manner of Death  1 Natural 5 Pending 2 Accident investigat	28a. Date of Injur (Month, Day		b. Time of		8c. Injury Work		2	8d. Describe ho			·y)
DIVISION	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the fune	Certification:	3 ☐ Suicide 6 ☐ Could not determine		ury - At home c. (Specify)	, farm, str	reet, factory	, office		2	8f. Location (Si City or Town		ber or Rui	ral Route Number,
	he Hospi in 24 hour he Funer pletely fill	Medical	(Check only 2   Medical Ex	Physician: To the best of aminer: On the basis of and manner sta	examination	dge, deati and/or in	vestigation,	, in my op	inion, deal	d place, a th occurre	d at the time, d	ate and place	, and due	to the cause(s)
	To t To t	Σ	29b. Signature and title of certifier	M. D				License	9107			9d. Date signi		
	5		30. Name and address of person wh	o completed cause of de			Print)							
	Sta	ite	31. Date filed (Month, Day, Year)	32. Registra	ar's Signature	المهاات	N AV	ZNINE	. 194	-11/V	nore 1	0 -	1-13	,
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crn			1 - State Registrar		artment of H artificate of I		ntal Hygier Reg. i	ZIIIIA	07601
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	/Medic Examin		4a. Facility Name (If not institution, give street and number	per)	·	r Location of Death		1 2006 4c. County of Death	6:28 P M
3	Funeral			Age (In yrs. last birthday	Balti Days	If Under 24 Hrs.   8	Date of Birth	N/A	nplace (State or Foreign untry)
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	should be filed within 72 hours after death with the Maryland nd Mental Hygiene. I marked other than "natural", or Itama 23a or 28a-f show umatic event, Ita Medical Exactinar mast te notified at	tor	Maryland NA	10c. City, Town or L	ocation Fintore				10d. Inside City Limits 1 XYes 2 No
	with the a or 28s	Directo	10e. Street and Number	D. V A.	10f. Zip Code	212	10g.	Citizen of What Co	untry?
	r death	Funeral	11. Marital Status  12. Was Deced	ent Ever in U.S. 13	. Was Decedent of H If Yes, specify Cuba	ispanic Origin? (Speci an, Mexican, Puerto Ri	fy Yes or No- can, etc.)	14. Race - Ame Black, White	
036	ours afte rai', or it Exertin	þ	1 Never Married 2 Married 1 Yes 2 If Yes, Give Year or Dat	X No	1 ☐ Yes 2 🕱 No	Specify:		Specify: B	lack
215-0	nin 72 hours In "natural", Medical Exe	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4)	(Giv	edent's Usual Occup e kind of work done o DO NOT use retired	during most of working	16b	Kind of Business/	Industry
d 212	filed with Hygiene ther the	e Com	17. Father's Name (First, Middle, Last)	Scl	nool C	UStodio 18. Mother's Name (	First Middle Maio	Sant	ation
ylan	d 2 should be filed within 72 hou th and Mental Hygiene. 7 is marked other than "natural freumatic event, Ita Medical E	To Be	Mack Gee			Marjo	rie C	loude	2
Mar	ges 1 and 2 should it of Health and Mer if Item 27 is marke or other treumatic		19a. Informant's Name/Relationship (Type, Print)   S	15ter) 196. Mai	ing Address (Street:	and Number or Rural I	Route Number, Cit	y or Town, State, 2	(ip Code) 21213
Baltimore, Maryland 21215-0036	Pages 1 a nent of Hei int: If Item iry or othe		20a. Method of Disposition  1 M Burial 2 Cremation 3 Removal from St	20b. Place of Disp	osition (Name of ematory or other place	(a) 3/16/	200/	Location - City or	Town, State
Saltin	permit. Page Depertment Importent: If any Injury or once.		4 Donation 5 Other (Specify)  21. Signature of Funeral Service Licensee	7 181917	Name and Address		ineral	unaa Home (	NIMO.
	205#9		23a. Parti Enter the disease, or complications that can shoty, or heart fail fre. List only one cause on ear	eed the death. Do not e	oseph Line 222 W. No	ig, such as cardiac or	Balto,	VId. 2121	Approximate
	Priysician		Immediate Cause (Final	arrhythmia	•				Interval Between Onset and Death
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,09	be executed icien and burial-transit	ai Exa	annuiting in death \ 1 and	as a consequence of):					
Division of Vital Records, P.O. Box 6876	To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physicie completely filled in by the funeral director, page 2 should be detached for use as the bur	Physician/Medical	JF FEMALE:					1	
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ords,	equires en signi ould be	ted by		•				2 □ No 3 □ Pro	V/
Reco	he law r e has be age 2 sh	Completed					24a. Was an autopsy performed	prior to death?	topsy findings available completion of cause of
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J of	ng Physiter this control direction	on: To	27. Manner of Death 28a. Date of		of 28c. Injun	4   Nuising Home	5 Residence d. Describe how in		mat scene
risio	Attendir death. ctor: Af	ertification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of	f Injury - At home, farm, s	M 1 🗆	Yes 2 □No	f. Location (Street	and Number or Ru	ıral Route Number.
ρi	pital or nurs after eral Dire	O	4   Authorite	, etc. (Specify)			City or Town, St	ate)	
	the Hosi in 24 ho the Fun ipletely f	edicai	29a. Certifier  (Check only one)  1 Certifying Physician: To the base and manner	is of examination and/or i	ith occurred at the fin nvestigation, in my o	ne, date and place, an pinion, death occurred	d due to the cause at the time, date	e(s) and manner as and place, and due	stated. to the cause(s)
	with To To	×	29b. Signature and title of certifier		29c. Licens	e number		Date signed <i>(Monti</i> rch 12, 2	
	24		30. Name and address of person who completed cause	of death (Item 23a) (Type	e, Print)	, Baltimor		····	
	Sta		31. Date filed (Month, Day, Year) 32. Re-	gistrar's Signature	IIII DOLECC	, Darchior	- FIGLY	212VI	-
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			1 - For State Registrar	State of Ma	aryland				ealth a D <i>eath</i>	ind M		jiene leg. No.	006	07602
2	Physici /Medi		Decedent's Name (First, Middle, Last)     MICHAEL	D.	COE						2. Date of Dea Month MARCH 1		06 Year	3. Time of Death 10:50A M
	Examir	ner	4a. Facility Name (If not institution, give s 1501 LIGHT STREE				BALI	IMOR				4c. (	N/A	th
₹.	Funeral Director		5. Social Security Number 6. Sex 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	7. Ag	e (In yrs. Ia 50	yrs.	If Unde Months	1 Year Days	If Under 2 Hours	Min.	8. Date of Birth (Month, Day May 4,	Vear	9. Bir Co Mar	thplace (State or Foreign cuntry) cyland
	e Maryland ta-f show lifted at	ctor	10a. State 10b. County Maryland N/A		10c. City,	Town or Lo	cation Balti	nore						10d. Inside City Limits 11√ Yes 2 No
	th with the 23s or 28	ai Director	10e. Street and Number 1501	Light St	٠,		10f. Zip	Code	21	1230			en of What Co JSA	ountry?
9000	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene.  If Item 27 Is marked other than "naturel", or Items 23a or 28a-f show or other traumatic event, the Moultal Examinar must be notified at	d by Funeral	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 _Yes 2 XI If Yes, Give Year or Dates:			Vas Dece Yes, spe		spanic Orig n, Mexican, Specify:	gin? (Spe , Puerto	ecify Yes or No- Rican, etc.)		4. Race - Ame Black, Whit Specify: Wh	te, etc.
Maryland 21215-0036	filed within 72 h Hygiene. other than "natu	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) 12  College (1-4or 5+) 12  Indicator (Give kind of work done during most of working life. DO NOT use retired)  Manager  18. Mother's Name (First, Middle, Last) Andrew Jackson Coe  Restaurant  18. Mother's Name (First, Middle, Maiden Surmame)  Celesta Esperence Green  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code							•				
/land	2 should be file and Mental Hy le marked oth raumatic event	To Be	17. Father's Name <i>(First, Middle, Last)</i> And r	Andrew Jackson Coe  Represented the strict of the strict o							ı			
	and 2 sho ealth and I m 27 le me		Jeanne Marie Melto	a. Informant's Name/Relationship (Type, Print)  eanne Marie Melton Coe (Wife)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  1501 Light St., Baltimore, Md. 21230  Method of Disposition  20b. Place of Disposition (Name of Disposition									Zip Code)	
Baltimore,	Pages 1 ment of H ant: If Itel lury or oth		20a. Method of Disposition  1   Burial 2 □ Cremation 3 □ R  4 □ Donation 5 □ Other (Specify)	emoval from State	Cel	nce of Dispo metery, cren dar Hi	natory or c	ther place	ery		5/06		-	Town, State Maryland
Balt	permit. Page Department of Important: If any injury or once.		21. Signatura of Fundral Service License	⇔ Kevin E	Ecke	r 22 M 1	Name ar IcCu1 30 E	ly-Po Ly-Po For	s of Facility Unic	ak F	uneral H alto., N	Home, Id.	P.A. 21230	
8760,	death certificate be executed  Parameter as the burial-transit  A for use as the burial-transit	Jicai Examiner	23a. Paft1. Enter the disease, or complishock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as	a conseque	nnce of):	0	2 C		arolac C	respiratory an	est,		Approximate Interval Between Page and Death Page 1
O. Box 6	death certif e attending id for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 pronths? 1 ☐ Yes 2 D No 9 ☐ Unknown	3c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal o	death 3	Ectopic pi Other (sp					23	d. Date of del Month	ivery Day Year
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Division of Vital Records,	ding Phys h. After this funeral di	To B	examiner?	ospital: 1 ☐ Inpatie 28a. Date of Injui (Month, Day	у 2	R/Outpatien 28b. Time of Injury		8c. Injury Work	r: 4 🗆 Nur:	sing Hor	me 5 Reside	ence 6	□Other (Specoccurred	cify)
Divis	of after	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Inju- building, etc	iry · At hom :. (Specify)	ne, farm, stre	et, factory	r, office		3	28f. Location (Si City or Town		Number or Ru	ura! Route Number,
	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	edical	29a. Certifier (Check only one) Certifying Phys	ician: To the best of er: On the basis of and manner sta	examination	ledge, death on and/or inv	occurred estigation	at the time in my op	a date and inion, death	l place a	and due to the co	ate and p	nd manner as lace, and due	to the cause(s)
)	Tot	Σ	29b. Signature and title of certifier	A VA	1	Lu/		: License		2			signed (Monti	
	U.		30. Name and address of person who con			33a) (Type, 1	Print)	udd,	Na	nsi	ior st	13	1/4	21275 31275
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DHMH 17 Rev 1/2001

Registrar

State of Maryland / Department of Health and Mental Hygiene 📋 🗎 🖯 Certificate of Death Reg. No. 2. Date of Death 3 Time of Death 1. Decedent's Name (First, Middle, Last) 8 Day 2006 Year March **Physician** 4:43 ам Linda Gayle Cross /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Greater Baltimore Medical Center Towson If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 □ F Dec. 12 1944 218-44-2355 California Director Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "naturel", or items 23a or 28a-f show other traumatic event, the Nedical Examinist must be notified at 1 ☐ Yes 2 ☐ No Director MD **Baltimore Nottingham** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4323 Apt. 103 Bedrock Circle USA 21236 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Yes No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No altimore, Maryland 21215-0036 Specify. white þ 3 ₩ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Medical 12 2 Nurse Department of Health and Mental Hygic Important: if item 27 is marked other tasmanland 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Alva Ruth Burruss Egbert Hale Epperson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 4323 Apt. 103 Bedrock Circle, Nottingham, MD Robert J. Weitzel/son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages 'Department of h Survial 2 Cremation 3 □ Removal from State □ Doration □ □ Other | Specify) 3/11/06 Dulaney Valley Memorial Gardens Timonium, MD 22. Name and Address of Facility Lemmon Funeral Home of Dulaney Valley, Inc. 10 W. Padonia Rd., Timonium, MD 21093 Lowell M. Lemmon Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) -ores DITHON **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine executed Due to (or as a consequence of) P.O. Box 68760 or Attending Physician: The law requires that the death certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 1 Live birth in the past 12 months?
1 ☐ Yes 2 ☑ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š Division of Vital Records, 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 1 ☐ Yes 2□ No 1 ☐ Yes After this certification funeral director, I 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: 1 Inpatient Medical Certification; To 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural Injury s after de. 5 Pending 1 Yes 2 No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospitel o within 24 hours all To the Funeral Di completely filled in 1 Contifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) Type, Print) 5061 Loch Rewen BINA, Bo 31. Date filed (Month, Day, Year) 32 Registrar's Signatu State 2006 Registrar 4

			For State Registrar	State of Maryland / I	Department of Health and I Certificate of Death	Mental Hygiene	IIII n	07605
	Physicia /Medic Examin	an ai	1. Decedent's Name (First, Middle, Last)  Jean Car  4a. Facility Name (If not institution, give s		4b. City, Town, or Location of Death		3 2006 County of Death	3; 55 A M
	Funeral Director		217 30 3604	7. Age (In yrs. last bi		Arylund  8. Date of Birth (Month, Day, Year) 7-1-33	9. Birthp Cour	place (State or Foreign ntry)
	ле Maryland 8a-f show	ector	Usual Residence of Decedent  10a. State 10b. County  AD ATM	3RE 10c. City, Tow	BALTIMORE	40-0	itizen of What Cou	10d. Inside City Limits
36	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other then "natural", or items 23a or 28a-f show or other traumatic event, it a Mudical Exact or matter colling at	by Funeral Director	10e. Street and Number  200 Vermon  11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1   Yes 2 I No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puerl		14. Race - Americ Black, White,	can Indian,
d 21215-0036	filed within 72 hou Hygiene. kther than "natura int, its Medical E	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)		Decedent's Usual Occupation (Give kind of work done during most of work ife. DO NOT use retired)  Lacher  18. Mother's Nar		Kind of Business/In	Public School
, Maryland	1 and 2 should be Health and Mental iem 27 is marked o	To Be	19a. Informant's Name/Relationship (Ty	8 several -not	b. Mailing Address (Street and Number or R	W. BAUDIN	WORF M	10 21234
Baltimore,	permit. Pages 1 s Department of He important: If item any injury or oth		20a. Method of Disposition  1 Method of Disposition  1 Method of Disposition  3 Great and Service License	emoval from State Parku	of Disposition (Name of iny, crematory or other place)  22. Name and Address of Facility	Date 200. L Ho-OG PATIMOR	ACTIMOR E, MD	5 MD 21234.
	Physician /Medical		23a. Part. Enter the disease or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	Renal Cell (	not enter the mode of dying, such as cardial			Approximate Interval Between Onset and Death
3760, A	eath certificate be executed attending physician and for use as the burial-transit	icai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence  Due to (or as a consequence  Due to (or as a consequence	of):	<b>Y</b>		
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Vital Rec	ian: The law rtificate has b stor, page 2 sh	Se Completed	25. Was case referred to medical		26. Place of De	24a. Was an autopsy performed?  1 Yes 2 N ath (Check only one)	prior to co death?	opsy findings available ompletion of cause of
Division of V	To the Hospital or Attending Phyaician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director. page 2	Certification: To B	examiner?  1	(Month, Day Year)	Time of Injury at Work?  M 1 Yes 2 No	Home 5 Residence 28d. Describe how inju	ury occurred	
Divi	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	al Certifi	4 Homicide determined  29a. Certifier 1 Certifying Phy	28e. Place of Injury - At home, building, etc. (Specify)	ge, death occurred at the time, date and place	e, and due to the cause(	s) and manner as	stated.
	To the H within 24 To the Fi completel	Medical	29b. Signature and title of certifier	and manner stated.	29c. License number	29d. D	nd place, and due thate signed (Month)	. Day, Year)
	Sta Regist		Pachel Salit 3 31. Date filed (Month, Day, Year)	completed cause of death (Item 23a 501 St. PLUL DI 32. egistrar's Signature			·CII	200 %

DHMH 17 Rev 1/2001

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State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death MARCH 10, **Physician** HARRY W. COOK, JR. 2006 5:00p M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b, City, Town, or Location of Death Examiner STELLA MARIS HOSPICE COCKEYSVILLE BALTIMORE If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth June 11, 1934 Birthplace (State or Foreign Country) 5 Social Security Number 6 Sex **Funeral** Months Days Hours **№** M 2 F 147-24-6267 71 Yrs. Director Usual Residence of Decedent the Maryland 10c. City. Town or Location 10d. Inside City Limits 10h County 10a State 28e-f ehow the Medical Examiner must be notified at ME WASHINGTON EASTPORT 1 Tyes 2 TNo Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö 45 WASHINGTON STREET 04631 USA Items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White etc I □ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ō 1 ☐ Yes 2 ☐ No Specify: Specify: WHITE 2 3 ☐ Widowed 4 ☐ Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) MANUFACTURE REP. OWN BUSINESS 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be and Mental I HARRY W. COOK, LILLIAN HALE ပ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Heelth a Importent: If Item 27 is any injury or other trai once. PEGGY COOK wife 45 WASHINGTON ST. EASTPORT, ME 04631 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Maurial 2 Cremation 3 Removal from State MT. ROCK CEMETERY 3/17/2006 MIFFLIN CO., PA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility HENRY W. JENKINS & SONS CO. 21. Signature of Funeral Service Licensee 16924 YORK RD. MONKTON, MD 21111 23a. Part 1. En er the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician LUNG CANCER /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner nding physicien and use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Month Year 4 Pregnant at time of death 5 ☐ Other (specify) cete has been signed by the a page 2 should be detached to Records, P.O. 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 MUnknown Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No certificete 1 Yes 2X No Division of Vital or Attending Physicien: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Nother (Specify) HOSPICE ၉ 1 ☐ Yes 2 📉 No 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification; After Injury 1 Natural 5 Pendina 1 Tes 2 No death. investigation ours efter death.
nerel Director: A 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours e To the Funerel L 29a, Certifier 1 🗶 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. ş 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TIMONIUM, MD 21093 2300 DULANEY VALLEY RD. TARIQ MAHMOOD 22. Registrar's Signature 31. Date filed (Month, Day, Year) State MAR 1 4 2006 Registrar finalle

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		For State Registrar	State of Marylar		partment of F ertificate of			giene Reg. No. UU 6	07607
Physicia /Medic		1. Decedent's Name (First, Middle, L THELMA E.	CHAMPNESS				2. Date of De Month	Day Year	3. Time of Death
Examin		4a. Facility Name (If not institution, gi	: HOSDITAL 9000+	ranki	4b. City, Town, o	or Cocation of Death	8. Date of Bir	40, dounty of Dea	more
uneral irector		5. Social Security Number 6. 215-14-0838  Usual Residence of Decedent	Sex 7. Age (In yrs. 83	Yrs	Months Days	Hours Min.	NOV .	<sup>th</sup> 25, 1922 9. Bii	thplace (State or Foreigr ountry) MD .
or 28e-f show a notified at	tor	10a. State 10b. County  MD BALTIMO		ty, Town o	Location ASTWOOD		·		10d. Inside City Limits 1 ☐ Yes 2 ☐ No
3a or 28 si ke noi	Funeral Director	10e. Street and Number 7222 GOUGH STREE	T		10f. Zip Code	21224		10g. Citizen of What C	ountry?
T result and wester hygeries in the same 23s or 28s-1 show them 21 is marked other than "natural", or items 23s or 28s-1 show other traumatic event, the Medical Exercities in this continued at	þ	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	.S.	3. Was Decedent of Hilf Yes, specify Cub	Hispanic Origin? (Span, Mexican, Puerto Specify:	pecify Yes or No Rican, etc.)	Black, Whi	
n "natural", Vedical Exa	Completed	15. Decedent's (Specify only highest g		(G	ecedent's Usual Occup live kind of work done e. DO NOT use retire	during most of work	king	16b. Kind of Business	s/Industry
nd mental hyglene. marked other than matic event, the Me	0	12TH  17. Father's Name (First, Middle, Last	0	S	ECRETARY	18. Mother's Nam	ne (First, Middle	STEEL CO	MPANY
and Mente	ToB	GEORGE NEIDHARDT		19b. M	ailing Address (Street	EMMA and Number or Ru	ral Route Numb	per, City or Town, State,	Zip Code)
Item 27 Is other trau		THOMAS OLDEWURTE			3 LYNHAM (	CT., BEL	AIR, MA	RYLAND 210 20c. Location - City o	
Department or Important: If It any injury or o once.		1 ☐ Burial 2 【A Cremation 3 `4 ☐ Donation 5 ☐ Other (Spec	□Removal from State ify) ME	cemetery,	CREMATORY	3/1:	3/06	BALTIMORE,	MARYLAND
Import any in		21. Signature of Funeral Service Lie	nsee					S. ZEILER & ORE, MD. 21	
ysician		23a. Part1. Enter the discase, or co shock, or heart anure. List on Immediate Cause (Final disease or condition		th. Do not		ng, such as cardiac			Approximate Interval Between Onset and Death
Medical ample sthe prival-transit	dical Examiner	resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Septic for as a consect of the physical consect of the physical consect of the physical consect of the physical consect of the physical consect of the physical consect of the physical consect of the physical consect of the physical consect of the physical consect of the physical consect of the physical consecution of the physical con		aray E	eunona eunona ed Syr			
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eath. or: After th he funeral	Certification:	27. Manner of Death  1 Natural 5 Pending 2 Accident investigat 3 Suicide 6 Could not		28b. Tin Inju	iry Wo	iry at ork? ] Yes 2 □ No		how injury occurred	
within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Certifi	3 ☐ Suicide 6 ☐ Could not determine		nome, farm	, street, factory, office			(Street and Number or I own, State)	Hu <i>ral Houte Number</i> ,
n 24 hou ne Funei sletely fill	edical		Physician: To the best of my kn aminer: On the basis of examin and manner stated.						
To the comp	Me	29b. Signature and title of certifier	8 50 M	$\mathfrak{D}$		006190	7	29d. Date signed (Mo	
1		30. Name and address of person who have a support of the support o	o completed cause of death (Ite	m 23a) (T	(pe, Print)	are Av	, R	obtimare,	MD 21291

State Registrar

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2006 32. Registrar's Signature

			1- Stete Amend Item 2	State of Maryla per verb.,	nd / Departm <b>853,03/1</b> 4/ <i>Certific</i>	ent of Health and 2006dbb ate of Death	Mental Hy	giene Reg. No: 006	07608
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	Physici /Medi		reser			eman	March	07 2000	6 1528 M
4	Examir	ner	4a. Facility Name (If not institution, give	street and number)	4b. C	ity, Town, or Location of Dea	th - /	4c. County of Dea	ath
			The Johns	Hopkins Ho	sspital B	der 1 Year   If Under 24 Hrs	-144		
	Funeral Director		5. Social Security Number 6. Se 212-78-2863		s. last birthday) If Un Mont			th y, Year) 9. Bi	rthplace (State or Foreign country)
			Usual Residence of Decedent				9-1-6	4 SC	·
	yland 10w		10a. State 10b. County		City, Town or Location				10d. Inside City Limits
	Mar.	to	MD	Ва	ltimore				1 A Yes 2 No
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	23a (11)	Funeral Director	1634 N. Milton	Ave.		21213		U.S.A.	
	ems ems	Iner	11. Marital Status	12. Was Decedent Ever in Armed Forces?	U.S. 13. Was De	ecedent of Hispanic Origin? (Specify Cuban, Mexican, Puer	Specify Yes or No	- 14. Race - Am Black, Wh	
36	or it	by Fu	Wever Married 2 Married	1 ☐ Yes 2 XNo If Yes, Give		s 2000 Specify:	,,	Specify: B1	
21215-0036	be filed within 72 hours after death with the Maryland stal Hygiene.  ad other than "naturel", or items 23a or 28a-f show event, the Medical Examinar must be notified at	d be	3 Widowed 4 Divorced	Year or Dales:	16- 5				
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lan	should be filed within ad Mental Hygiene. marked other than imatic event, the M	To B	Paul L. Small			Dorothy	y Bucha	nan	
Maryland	2 should and Men is marke		19a. Informant's Name/Relationship (T)	rpe, Print)	19b. Mailing Addr	ess (Street and Number or R	ural Route Numbe	er, City or Town, State,	Zip Code)
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Baltimore,	00		20a. Method of Disposition 1	Removal from State	Place of Disposition (	Name of 3 - 14	Date 1 - 0 6	20c. Location - City o Dundalk, M	
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Sall	Departm Departm Importa any nju		21. Signature of Funeral Service Aicens	ee 0/ /		and Address of Facility We 7 Eastern Av			
	707 # 0		Muly	Mar to					T
			23a. Part1. Enter the disease, or compleshock, or heart failure. List only o	ne cause on each line.	ath. Do not enter the n	node of dying, such as cardia	c or respiratory ar	rrest,	Approximate Interval Between Onset and Death
4	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	prolonged	· Cardio	pulmonary	arre	54	S Days
т	Examiner			Due to (or as a)cons	equence of):	- /			CL N
		9	Sequentially list conditions, if any, leading to immediate	Due to (or as a conse	Sepsis				7 Days
	ansit	듣	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	anoxic	brein	Survey			5000
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Вох	eath certific attending p	an/	230. Was decedent pregnant	23c. If yes, outcome of preg 1 ☐ Live birth 2 ☐ Fe		c pregnancy		23d. Date of de	
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	To To To To To To To To To To To To To T	Σ	29b. Signature and title of certifier			29c. License number		29d. Date signed (Mon	
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(	0		Migue   Munoz.	ompleted cause of death (It	em 23a) (Type, Print)	zet, Baltimo	va MD	21282	
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Sig	natura de la la la la la la la la la la la la la	wi, Danino	14 1711)	41404	
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#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death Dey Month Year **Physician** UKES 60 JUIN 10 00 /Medical 4b. City, Town, or Location of Death 4a Fecility Name (If not institution, give street end number) 4c. County of Death Examiner DREEN timore If Under 24 Hrs. If Under 1 Year 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours South 218-14-64 ( y Usuel Residence of Decedent 10b. Cour 184M 2□ F Director Pages 1 and 2 should be filed within 72 hours efter death with the Maryland nent of Health end Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23s or 28e-f ahow 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Ves 2 □ No **Funeral Director** Maryland saltimore 10e. Street end Number 10g. Citizen of What Country? 10f. Zip Code Was Decedent Ever in U,S. Armed Forces? 1 X Yes 2 □ No If Yes, Give 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: Specify: Completed by 3 Widowed 4 □ Divorced Year or Dates: 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 04 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be pson 19e. Informant's Name/Relationship (Type, Print) (Sister) 19b. Meiling Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) Mae Balto, Md lanes 20b. Place of Disposition (Name of cemetery, crematory or other p Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremetion 3 □ Removal from State 20/2006 ŏ 4 ☐ Donation 5 ☐ Other (Specify) son rores 21. SignatOre of Funeral Service Licensee 22. Name and Address of Facility Funeral Home, P.A. Joseph L. Rus 2222 W. North AUR, Enter the disease, or complications that daused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical ADENOCARCINOMA STOMACH OF Un Krown Examiner Due to (or as a consequence of) edical Certification: To Be Completed by Physician/Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours effect death. To the Funeral Director: After this certificate has been signed by the attending physician end completely filled in by the funeral director, page 2 should be deteched for use as the buriel-transit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Due to (or as e consequence of): Pert II. Other algnificent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? SEIZUNE 2100 1 ☐ Yes 2 ☐ No 1 Yes 25. Was case referred to medical examiner? 26. Place Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 TYes 2 No 27. Menner of Death 28a. Date of Injury (Month, Dey Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Netural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28f. Location (Street end Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. 29a. Certifier

State Registrar

end address of person who completed cause of death (Item 23e) (Type, Print)

(Check only

29b) Signature and title of certifie

31. Dete filed (Month, Day, Year)

4 2006



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WEST 1600

29c. License number

12005905

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29d. Date signed (Month, Day, Year)

MO 21217

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	Dhuaiai		1. Decedent's Name (First, Mi	ddle, Last)								<ol><li>Date of Dea Month</li></ol>	ith Day	Year	3. Time of Death
	Physici /Medio		Valerie Do	ighert	У							MARCH 8	1		07:46"
	Examir		4a. Facility Name (If not institu	tion, give sti	reet and number,	)		1		Location of	of Death			ounty of Death	
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	Funeral		5. Social Security Number	6. Sex 1 □ 1	M 25√2 F 7. A		ast birthday) Yrs.	If Under Months	Days	If Under Hours	Min.	8. Date of Birt (Month, Day	r, Year)		nplace (State or Foreign untry)
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	r 28.	Funeral Director	10e. Street and Number					10f. Zip	Code				10g. Citize	n of What Co	untry?
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Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel; or items 23a or 28s-1 show any njury or other traumatic event. The Madical Examinational De notified at Ance.		1 ☐ Burial 2 ☐ Crematic		moval from State	Ç6	emetery, cre	matory or o	ther place	θ)				•	
Ē	ritani njury		4 Donation 5 □ Oth	(Specify)	- 1		2:	Name an	d Addres	s of Facilit	tv				
Ba	Depa Impo		21. Signature of Funeral Service Royal de Conce	S. W	ade, Vi	ector	Si Ba	tate A			oard 2120	655 W.	Balt	imore	Street
			23a. Part1. Enter the disease shock, or leart failure.	a comclication	ation that cause cause on each	ed the death line.	n. Do not en	er the mod	e of dying	g, such as	cardiac o	or respiratory ar	rest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition		Cono	rest	ive	Hea	irt	Fai	du	re			Onset and Death  S YEARS
	/Medical		resulting in death)	("	Due to (or a		uence of):								
Į.	Examiner		Sequentially list conditions,	b.	Ather	050	erot	ic	Car	dio	1050	ular	Dis	ease	loyears
	sit ød	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	~	Due to (or as	s a consequ	ience of):								•
	and tran-	cam	that initiated events resulting in death) Last	c.	Due to (or a	2 20020011	iance of):								
760,	ate be executed hysiclen and he burial-transit	cal E			D00 10 (01 a.	3 4 00/13040	201100 01).								
	physi the t			d.											
9 ×	death certificat e attending phy id for use es th	Physician/Med	IF FEMALE:	23	c. If yes, outcom	e of pregnar	ncv						00	d Date of deli	
Вох	atten for us	ian	23b. Was decedent pregnant in the past 12 months?	20	1 ☐ Live birth 4 ☐ Pregnant	2 Fetal	death 3	Ectopic p					230	<ul> <li>Date of deli</li> <li>Month</li> </ul>	Day Year
o	0 00 0	ysic	1 □ Yes 2 □ No 9 □ Unknown		9□ Unknown	at time or de	<b>3</b> 0	J Other (sp	ecily)						
P.0	that the de ned by the a detached f	된	Part II. Other significant cond	litions conti	ributing to death	but not resu	ulting in the u	nderlying c	ause give	en in Part I	l.	23e. Did to	obacco use	contribute to	the cause of death?
Records,	w requires that the been signed by the should be detache	d by										101	es 2 🛣	No 3□Pro	obably 4 Unknown
Ö	> 0 0	Completed										24a. Was	an	24h Were au	topsy findings available
Re	has pe 2	E D				-						autop perfo	rmed?	prior to death?	completion of cause of
_	ilcian: Th certificete rector, pag		OF Manager referred to man	inal		The same						1 ☐ Yes		1 🗆 Yes	2□ No
Vital		Be	25. Was case referred to med examiner?  1 ✓ Yes 2 ☐ No		spital:	iont 001	5B/0		Othe			Check only o		70.5 (0	4.1
of	Phys r this ral di	5	27. Manner of Death		28a. Date of Inj	ury	ER/Outpaties 28b. Time of		8c. Injury Work	4 🗆 190		me 5 Residence 128d. Describe 1			iny)
Division	ath. r: After te funer	ţi	1 Natural 5 ☐ Per 2 ☐ Accident inve	ding stigation	(Month, D	ay Year)	Injury	м		k? Yes 2 ☐	No				
/isi	Attendi death. ctor: A	fica	3 ☐ Suicide 6 ☐ Coi	ld not be	28e. Place of Ir	njury - At ho	me, farm, st	reet, factor	y, office					Vum <i>ber</i> or Ru	ral Route Number,
Ö	after after din b	Certification:	4 Homicide		building, e	etc. (Specify	")					City or Tov	vn, State)		
	To the Hospital or Attenc within 24 hours after death To the Funeral Director: completely filled in by the	Medical C	29a. Certifier 1 Certifier (Check only one)	ying Physi al Examine	cian: To the bes	of examinat	wledge, deat tion and/or in	h occurred vestigation	at the tim	ne, date ar pinion, dea	nd place, ath occurr	and due to the ed at the time,	cause(s) ar date and p	nd manner as lace, and due	stated. to the cause(s)
	thin 2 the mple	Med	29b. Signature and title of cer	ifier	and manner s	Deside		290	. License	a number			29d. Date	signed (Monti	n, Day, Year)
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			30. Name and address of pers	1 (1	1000				ATD -	. A 75.77	4370	01500			
			DR. JOSE LOVER 31. Date filed (Month, Day, Ye		12 SETON	DRIV. trar's Signat		IBERLA	AND, N	<u>taky L</u>	AND	21502			
	Sta Regist			906	/ Bak	K	Spare	الكا							

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 10 4 9:46 AM Lillian Elaine Diehl 2006 MARCH 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b City Town or Location of Death Harford Upper Chesapeake Medical Center Bel Air 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6 Sex Birthplace (State or Foreign Country) 1 □ M 2 🔀 F Days Hours 81 Yrs. 219-10-3881 1924 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10h County 1 ☐ Yes 2 XNo Harford Maryland Baldwin 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2706 Park Heights Drive 21013 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White, etc. ☐Yes 2XNo 1 Never Married 2X Married 1 ☐ Yes 2X No Specify: 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Edward Walshe Beatrice Patten John 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kenneth E. Diehl - Husband 2706 Park Heights Drive, Baldwin, Maryland 21013 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Fairview U.M. Ch. Cemt. 3/13/06 Phoenix, Maryland

4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility McComas Funeral Home, P.A. 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. > 50 West Broadway Street, Bel Air, Maryland 21014

Systemic Immediate Cause (Final flammatory disease or condition resulting in death) Due to (or as a consequence of): Preumonia Due to (or as a consequence of)

Year

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

**Physician** 

/Medical

Director

Completed by Funeral

Be

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Examine

Physician/Medical

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Completed

Be

Certification:

Medical

Examiner

**Funeral** 

Director

r than "natural", or iteme 23a or the Medical Examiner must be a

be filed within 7 al Hygiene.

marked

permit. Pages Department of Important: If it any injury or o

**Physician** 

Examiner

/Medical

burial-transit

Pages 1 and 2 should be nent of Health and Mental

Due to (or as a consequence of)

2□ No

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 9 Unknown

23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 Pregnant at time of death 9 Unknown

3 Ectopic pregnancy 5 Other (specify)

23d. Date of delivery Month

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

25. Was case referred to medical examiner?

24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes

1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending

1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28b. Time of investigation

28c. Injury at Work? 1 □ Yes 2 □ No

26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

2/X No

1 Yes

29a. Certifier (Check only

2 Accident

3 🗌 Suicide

4 Homicide

107 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

DO056607

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6 Could not be determined

ANGELO, #205, 602 S. ATWOOD Rd, BEL AFR, MD 21014 JOSEPH

Registrar

31. Date filed (Month, Day, Year) 2006



28e. Place of Injury - At home, farm, street, faclory, office building, etc. (Specify)

Attending Physician:

Hospital or within 24 hours a
To the Funeral I
completely filled pelli

hours after deat

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Division

			1 - For State Registrar	State of Mar	yland / Dep		lealth and N	Mental Hygid	<b>70</b> 06 07612
2.27		# 100 100	Decedent's Name (First, Middle, I	Last)		rimouto or	Dodin	2. Date of Death	g. No.  3. Time of Death
	Physic /Medi Exami	cal	Patricia  4a. Facility Name (If not institution, g	L. Davis		4b. City, Town, o	r Location of Death	MARCH	Day Year 7,00 AM  4c. County of Death
12	Examin	iei	Doctors Communi			Lanhar			Prince Georges
	Funeral Director				'In yrs. last birthday, Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, ) 02/15/1	9. Birthplace (State or Foreign Country)  937 Arkansas
	pur *		Usual Residence of Decedent  10a. State 10b. County	1	Oc. City, Town or Lo	ocation			10d. Inside City Limits
	e Maryla 3a-f sho	Director	Maryland Prince (		Bowie				1 Yes 2000
	with th	Pire	10e. Street and Number			10f. Zip Code		100	g. Citizen of What Country?
	eath v	erai	12813 Beech Tree	Lane 12. Was Decedent Eve	or in U.S. 12	20715		needy Vee or No	U.S.A.  14. Race - American Indian,
336	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Itam 27 is marked other than "natural", or Itama 23a or 28a-f show other traumatic event, the Modical Expounders, such be notified at	by Funeral	11. Marital Status     1 □ Never Married 2 □ Married     3 □ Widowed 4 🎖 Divorced	Armed Forces?	er in 0.3.	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 X No		Rican, etc.)	Black, White, etc.  Specify: white
21215-0036	in 72 hou n "nature	Completed	15. Decedent's (Specify only highest	Education grade completed)	(Give	dent's Usual Occup kind of work done DO NOT use retired	pation during most of world)	king 16	6b. Kind of Business/Industry
212	d with giene	mo;	Elementary/Secondary (0-12)	College (1-4or 5+)					r Printing Business
Maryland	2 should be filed within and Mental Hygiene. Is marked other than aumatic event, the Ma	To Be C	17. Father's Name (First, Middle, La Earl H. Neagle	st)				ne (First, Middle, Ma • Tarpley	,
	1 and 2 should Health and Men am 27 Is marks ther traumatic		19a. Informant's Name/Relationship			-		ral Route Number, (Bowie, MD	City or Town, State, Zip Code)
Baltimore,	Pages 1 a nent of Hes int: If Itam iry or othe		20a. Method of Disposition 1   Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spe	Removal from State	20b. Place of Dispo cemetery, cre	osition (Name of matory or other place	ce)	Date 20	oc. Location - City or Town, State
altir	그 문문을 .		21. Signature of Funeral Service Lig		Fort Linc	OIN Cemet  2. Name and Addre			In Funeral Home
ä	Dermi Depa Impo eny in		San 4. 5	Till	3	401 Blade			rood, MD 20722
760, 6	Physician Age of the paragraph of the pa	ai Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a condition of the cond	consequence of):	osclerotic	Catcher	rascular	Disease 10 4861
P.O. Box 687	it the death certifics by the attending pt lached for use as t	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 Live birth 2 4 Pregnant at time	Fetal death 3	☐Ectopic pregnancy ☐ Other (specify)	(		23d. Date of delivery Month Day Year
Records, F	quires tha n signed uld be de	Completed by P	Part II. Other significant conditions Insulin Dependent	contributing to death but r	not resulting in the u		en in Part I.	23e. Did toba 1 ☐ Yes	acco use contribute to the cause of death?
000	law requir as been si 2 should	piete	Chronie Ren	al Disease				24a. Was an	24b. Were autopsy findings available prior to completion of cause of
Vital Re		e Com	Chycnic Obstruction Was case referred to medical	ctive Pulm	onary.	Disease	00 Plant of Part	100	prior to completion of cause of death?  1 Yes 2 No
N.	Physician: rthis certific ral director,	ToB	examiner? 1 ☐ Yes 2 No	Hospital: 1 Dinpatient	2 ER/Outpatier	nt 3 DOA Oth	05	th Check only one	ce 6 ☐Other (Specify)
ion of	ling Ph		27. Manyfer of Death 1 DNatural 5 Pending 2 Accident investigat	28a. Date of Injury (Month, Day Y		f 28c. Injur Wor		28d. Describe how	
Division	To the Hospital or Attanding within 24 hours after death.  To the Funeral Director: After completely filled in by the fune	Certification:	3 Suicide 6 Could not determine		r - At home, farm, sti (Specify)	reet, factory, office		28f. Location (Stre City or Town,	et and Number or Rural Route Number, State)
	le Hospita 124 hours le Funera Jetely fille	edical (	29a. Certifier 1 Certifying 1 (Check only one)	Physician: To the best of radiner: On the basis or examiner: and manner stated	kamination and/or in	h occurred at the tin vestigation, in my o	ne, date and place, pinion, death occur	and due to the cau	ise(s) and manner as stated. e and place, and due to the cause(s)
	To the To the comp	Me	29b. Signatural and hiteroric certifies	Postoria	#7	29c. Licens	6 89 1		d. Date signed (Month, Day, Year)  ARCH 5, 2006
-	7		30. Name and address of person who William D.		th (Item 23a) (Type, 8188 Go	Print) odluck Rd	Lanham	, MD20706	(C) (A) (C)==(A)
	Sta Registi		31. Date filed (Month, Day, Year)	32. Register's	s Signature	Scarles			

DHMH 17 Rev 1/2001

Putricia L

ORIGINAL

Physic /Medi Exami

Physician /Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

	1- State of Mary State of Mary Registrar	_	artment of H tificate of L		-	giene Reg. No. 0	06	07613
	Decedent's Name (First, Middle, Last)				2. Date of De.		V	3. Time of Death
ian	Rose Marie Deise				MARC	Day H Ø9,	Year 2006	8:44 PM
cal ner	4a. Facility Name (If not institution, give street and number)		4b. City, Town, or			4c. County	andre and a	
	Saint Joseph Medical C	enter		Tows	on		Balt	cimore
	5. Social Security Number 218-70-7679 6. Sex 1 M 200 4	n yrs. last birthday) 8 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	8. Date of Bin (Month, Da OCt • 1	y Year) 9,1957	Cou	place (State or Foreign intry) yland
	Usual Residence of Decedent	a City Town						404 1-14-07-11-1-
-	•	oc. City, Town or Lo						10d. Inside City Limits 1 ☐ Yes ② No
octo	4	Baltimore						
Completed by Funeral Director	100. Street and Number 10007 Nearbrook Lane		10f. Zip Code 21234			10g. Citizen of United		•
a a		sin 11 C 12 1		anania Origina (C				ican Indian,
nu.	11. Marital Status 12. Was Decedent Eve Armed Forces?  1 □ Never Married 2 □ Marned 1 □ Yes 2 ☒ No	r in U.S. 13. 1	Was Decedent of Hi f Yes, specify Cuba	n, Mexican, Puer	to Rican, etc.)		ck, White	
by F	3 ☐ Widowed 4 ☑ Divorced Year or Dates:		1□Yes 2⊠No	Specify:		Specil	y: Wh	ite
ed	15. Decedent's Education	16a. Deced	dent's Usual Occupa	ation		16b. Kind of B	usiness/ir	ndustry
plet	(Specify only highest grade completed)	(Give	kind of work done of DO NOT use retired	luring most of wo	rking			•
Ho	Elementary/Secondary (0·12) College (1·4or 5+)	Sale	es			Baltim	ore S	Sun
Be	17. Father's Name (First, Middle, Last)				me (First, Middle,		пө)	
To E	Michael Petro Ventura			Edna Ro	salie Ra	wlings		
-	19a. Informant's Name/Relationship (Type, Print)		ng Address (Street a					
	Mr. Troy A. Hawkins (Fiancee	) 10007	Nearbro	ok Lane,	Baltimo	re Mary	land	21234
	¥	20b. Place of Dispo cemetery, crer	natory or other plac	θ)	Date	20c. Location		
	4 Donation 5 Other (Specify)	Dulaney V	alley Mer	n. Marc	h 13,200	6 Timo	nium,	, Maryland
	21. Signature of Funeral Service Liceusee	F22	Name and Address Aceful A.	s of Facility Iternation	ves Fune onium, M	ral&Cre arvland	matic 2109	on Ctr.P.A.
	23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line.					-		Approximate Interval Between
	Immediate Cause (Final	arre poc	ACT CAN	- E7 E)				Onset and Death
	disease or condition resulting in death)  Due to (or as a co		AST CAN	ar lim FS				
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an/	23b. Was decedent pregnant 23c. If yes, outcome of p	oreg <i>nan</i> cy Tetal death 3	Ectopic pregnancy				ate of deliv	very Dav Year
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Completed by Physician/Me	Part II. Other significant conditions contributing to death but n	ot resulting in the u	nderlying cause give	en in Part I.		V		the cause of death?
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ple					24a. Was autor	SV A	prior to co	opsy findings available ompletion of cause of
5					perfo 1 ☐ Yes	2 No	death?	2 No
Be	25. Was case referred to medical examiner?				ath (Check only o	ne)		
ို	1 ☐ Yes 2 ONO Hospital: 1 ☐ repatient	2 ER/Outpatier		4 🗆 Nursing r	dome 5 ☐ Resid			ify)
On:	27. Manner of Death 12. Natural 5 □ Pending 28a. Date of Injury (Month, Day Ye	ear) 28b. Time of injury	Worl		28d. Describe	now injury occur	rred	
cat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be 380 Place of Injury			Yes 2 □ No	00/ 1			
E	4 Homicide determined 28e. Place of Injury building, etc. (3	- At home, farm, str Specify)	eet, factory, office		City or To		ber or Hur	al Route Number,
Ce	One Codffier 19 Codffie 20 11 11 11 11 11 11 11 11 11 11 11 11 11							
Medical Certification;	29a. Certifier  (Check only one)  1 Certifying Physician: To the best of m  2 Medical Exeminer: On the basis of ex and manner stated	amination and/or in	n occurred at the time vestigation, in my of	ne, date and place pinion, death occi	e, and due to the urred at the time,	cause(s) and m date and place,	anner as : and due !	stated. to the cause(s)
Σ	29b. Signature and title of certifier		29c. License	number		29d. Date signe	ed (Month,	Day, Year)
	Degrando Mella	m-0	D41	410	1	March	100	7 200 60
	30. Name and address of person who completed cause of death	h (Item 23a) (Type,	Print)					
		601 OSL	ER DRIV	E TOWSO	N, MAR	YLAND	2120	74
ate	31. Date filed (Month, Day, Year) 32. Figistrar's	Signature -	and i					
rar	MAR 1 4 2006	1 15 19	Con Second					

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			1 - For State Registrar	State of Maryla		artment of I		-	giene	6 07614
	Physici /Medic Examin	al	1. Decedent's Name (First, Middle, Last  JOHN WIL  4a. Facility Name (If not institution, give	LIAM I	SAVI	S Si 4b. City, Town, o	or Location of Death	2. Date of De Month	_	Year S. 10 P M of Death
	Funeral Director		5. Social Security Number 6. S 220-12-9267 1 Usual Residence of Decedent	REXTENDED  7. Age (In y  M 20 F  80	rs. last birthday) Yrs.	Ba1t If Under 1 Year Months Days	imore If Under 24 Hrs. Hours Min.	8. Date of Bin (Month, Da Sept 5		Birthplace (State or Foreign Country)     MD
	Maryland a-f show	tor	10a. State 10b. County MD Carrol		City, Town or Lo	esville				10d. Inside City Limits 1 ☐ Yes 2 🗓 No
9036	be filed within 72 hours after death with the Maryland tial Hyglene.  do other than "natural", or Items 23a or 286-f show event, the Medical Examinar must be notified at	d by Funeral Director	10e. Street and Number  270 K1ee Mill Ros  11. Marital Status  1 Never Married 2 Married  3 XWidowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 ∰Yes 2 ☐ No If Yes, Give Year or Dates: WW	II	1 ☐ Yes 2 📉 No	Hispanic Origin? (Sp an, Mexican, Puerto Specify:	pecify Yes or No o Rican, etc.)	Black Specify:	- American Indian, t, White, etc. White
21215-0036	filed within 72 h Hygiene. ether than "natu	Completed	15. Decedent's E. (Specify only highest gra	College (1-4or 5+)	(Give	dent's Usual Occup kind of work done DO NOT use retire	during most of word		Stee1	
Maryland	2 should be filed within and Mental Hygiene. Is marked other than eumatic event, the M	To Be	17. Father's Name (First, Middle, Last)  James R. Davis  19a. Informant's Name/Relationship (	5	19b. Maili	ng Address (Street	Mary  Mand Number or Ru	Houlih		
	1 and 2 Health ar tem 27 Is		Mr. Kenneth Davis  20a. Method of Disposition  1 X Burial 2 Cremation 3 C	(Son)  Removal from State	1307 b. Place of Dispo cemetery, cre	Lee Aven	ue Sykes	Date Date	ID 21784	City or Town, State
Baltimore,	permit. Pages Department of Important: If It eny Injury or o		4 □ Donation 5 □ Other (Specification of Funeral Service Licer		ΗŽ	ATGHT FUN	IERAL HOME	E & CHAP		195)
3760,	be attending physicien and the purification and the purification and for use as the burial-transit	lical Examiner	23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter 'Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a const.  Due to (or as a const.  Due to (or as a const.  Due to (or as a const.  Due to (or as a const.	sequence of):  LTD (0 sequence of):	ngue	ag, such as cardiac	or respiratory a	rrest,	Approximate Interval Between Onset and Death
P.O. Box 68	it the death certifica by the attending ph tached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	23c. If yes, outcome of pre 1 □ Live birth 2 □ F 4 □ Pregnant at time of	etal death 3[	□Ectopic pregnanc □ Other (specify) _	у		23d. Date Mon	o of delivery th Day Year
	The law requires that the ate has been signed by the page 2 should be detache	þ	Part II. Other significant conditions of	ontributing to death but not	resulting in the u	inderlying cause gr	ven in Part I.			bute to the cause of death?
Il Records,		Completed						24a. Was autor perfo 1 🗆 Yes	psy pr prmed? de	fere autopsy findings available for to completion of cause of eath?
Vital	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:		Ott	26. Place of Dea			
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Division	o te de	Certification:	3 Suicide 6 Could not b 4 Homicide determined	28e. Ptace of Injury - A building, etc. (Spe	t home, farm, st ecify)	reet, factory, office		28f. Location (. City or To		r or Rural Route Number,
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į	0 1		30. Name and address of person who	Ranen F	Slva,	Bal	tempe	, Muo	21218	3
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/Medical		disease or condition resulting in death)  a  Du to (or a	s a conseque	ence of):	cumen	uu				_	
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pital ours ours erel filled		29a. Certifier 1X3 Certifying Physician: To the bes	st of my know	riedge deat	h occurred a	t the time date	and place.	and due to the ca	ause(s) and mar	ner as s	ated
To the Hospital or Attending Physician: The law within 24 hours elter death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	edicai	(Check only 2 Medical Examiner: On the basis and manner:	of examination	on and/or in	vestigation,	in my opinion, d	eath occurr	red at the time, d	ate and place, a	nd due to	the cause(s)
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de		► 1911 <sub>1</sub>			D	3895	8		3/10	106	,
10		30. Name and address of per in who completed cause of	death (Item	23а) (Туре,	Print)	,	_	- 0	+ /		10 2106/
		Datiert Schab Sechu	708	Cra	en Hig	hory	Cw	Olin	Burna	, 1	1021061
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Division or Attending titer death. Director: Attention in by the fune	Certification:	27. Man Fr of Death  1 Natural 5 Pending 2 Accident 3 Suicide 6 Could not be determined	28a. Date of Injury (Month, Day Year 28e. Place of Injury - A building, etc. (Spe	At home, farn	M M n, street, factory, o		City or To	Street and Nu wn, State)	mber or Rura	al Route Number,
of Vita Physician: this certific	To B	1 195 2 140		2 ☐ ER/Outp		Other: 4 Nursing I	Home 5 ☐ Resi	dence 6 □		<b>(y</b> )
Vital Rec	0	25. Was case referred to medical	,			26, Place of De	auto	2 No	prior to co death? 1 Yes	opsy findings available impletion of cause of
cords, P	Completed by	Clostridiu	im Dif	ficil	le		1 □ '	Yes 2 No	3 ☐ Prot	bably 4 Unknown
	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  Part II. Other significant conditions cor	33c. If yes, outcome of pre- 1 ☐ Live birth 2 ☐ F 4 ☐ Pregnant at time of 9 ☐ Unknown	etal death of death	3 □Ectopic pregion of the condent o	fy)	23e. Did t		Date of delive	ery Day Year he cause of death?
76(	ledical Examiner	Sequentially list conditions, if any Jacobia to in modale cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a cons							
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Baltimor permit. Pages Department of Important: If the any injury or o		21. Signature of Funeral Service License		ulane		Mem. 3/1 Address of Facility  Kesbury Roa		s Funer	ral Hon	me, P.A.
Baltimore, Mar permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 1e m any injury or other traum ang.		William R. Eney −  20a. Method of Disposition  1 M Burial 2 □ Cremation 3 □ R  4 □ Donation 5 □ Other (Specify)	Removal from State	b. Place of E cemetery,	Disposition (Name, crematory or othe	r place)	Date	20c. Location	on - City or T	own, State
Taryla Taryla 2 should and Men ie marke	၉	19a. Informant's Name/Relationship (Ty	rpe, Print)	ibbage 19b. I		Pansy treet and Number or R		izabeth er, City or Too		Peyton Code)
yland 2  yland 2  build be filed  Mental Hygi  arked other atte event,	Be	17. Father's Name (First, Middle, Last)		1.1			me (First, Middle		,	
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ire, Maryland 21215-0036  s. 1 and 2 should be filed within 72 hours after death with the Marylan and Mental Hygiene. Item 27 is marked other then "natural", or Iteme 23s or 28s-1 show other traumatic event, the Medical Empires mainter notified at	ted by Funeral	1 Never Married 2 Married 3 XWidowed 4 Divorced  15. Decedent's Educy Specify only highest grade	Armed Forces?  1 Yes 2 No If Yes, Give Year or Dates:	16a. [	1 ☐ Yes 2 ☐	No Specify:		Spe	Black, White, wity:  Wh  Business/In	ite
death wit	eral D	303 Trimble Road	12. Was Decedent Ever in	n U.S.	2108	t of Hispanic Origin? (S Cuban, Mexican, Puer	Specify Yes or No	US 0- 14. F	Race - Ameri	
death with the Maryland me 23a or 28a-f ehow rmast be rediffed at	Director	Maryland Harford  10e. Street and Number		Joppa	10f. Zip Co	ode		10g. Citizen	of What Cou	1 ☐ Yes 2 ZiNo ntry?
2	-	Usual Residence of Decedent 10a. State 10b. County		City, Town	or Location	1				10d. Inside City Limits
Funeral Director		5. Social Security Number 6. Sex	7. Age (In y		day) If Under 1		8. Date of Bir (Month, Da Feb. 6	v. Year)	9. Birthi Cou Mary	place (State or Foreign ntry) yland
Examine		4a. Facility Name (If not institution, give s	street and number)	101	i//	wn, or Location of Deal	th	4c. Cou	nty of Death	iMAR
Physicia /Medica		Doris Lee	Eney				Month	Day	2006	C. O P M
		State     Registrar  1. Decedent's Name (First, Middle, Last)			Certificate	or Death	2. Date of De	Reg. No.	Ub	3. Time of Death

Please Type or Print in Black Indelible Ink., Ensure All Copies Are Legible.

Amend items 10b, d.e., f. per fh 8853 3-14-06 vt.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day D. EISENBERG **Physician** Year 2006 7:24 MARCH /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner enter 18 TOWN Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 2 F Yrs. Director Usual Residence of Decedent death with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits ?7 is marked othar than "natural", or Itams 23a or 28a-f show traumatic evant, the Madical Examinar must be notified at 1 Yes Z Director 6300 Place #400 Red Cedar 10f. Zip Code 10g. Citizen of What Country? 21209 Funeral 12. Was Decedent Armed Forces? 1 Yes 2 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. nent of Health and Mental Hygiene. ant: If itam 27 Is marked othar than "natural", or Ital 1 Never Married 2 Married 2 No Baltimore, Maryland 21215-0036 þ 1 ☐ Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) OWNER HARDWARE MANUFACTURING 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be **EISENBERG** SARAH GREBOW BENJAMIN ٩ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) itam 27 l 6300 RED CEDAR PLACE #400 - BALTIMORE, MD 21209 SYLVIA F. EISENBERG / WIFE 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of H Important: If its any injury or ot once. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State BETH TFILOH CEMETERY 03/13/2006 WOODLAWN, MD <sup>¹</sup> 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician ARTERY DISEASE DRONARY /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury Due to (or as a consequence of): Examiner burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760. iding physician ise as the buria Be Completed by Physiclan/Medical IF FEMALE: use 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Year 4☐ Pregnant at time of death 5 Other (specify) 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, CARDIOMY OF ATHY. 1 ☐ Yes 2 ☐ No 3 🗌 Probably RENAL 24b. Were autopsy findings available prior to completion of cause of death? ACUTE 24a. Was an autopsy 1 ☐ Yes 1 🗌 Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one Hospital: 1 npatient ျှ 1 ☐ Yes 2 No Cther: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 27. Manner of Death
1 Natural
2 Accident 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? Certification: 28d. Describe how injury occurred 5 Pending investigation death. 1 ☐ Yes 2 ☐ No after death the 6 ☐ Could not be within 24 hours after de To tha Funaral Diracto completely filled in by th 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29c. License number 0 42723 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) HYSICIAN 3006 MARCH 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NORTH WEST 10 CENTER HOSPITAL HARISH AVYERA MALLI 5401 OLD COUNTY ROAR 31. Date filed (Month; Day, Year) 32 Registrar's Signature State Registrar 2006

			1_ For State	State of Maryla		nent of Health and	Mental Hygien	Ponc	07618
			Registrar		Certifi	cate of Death	Reg. No	.000	0/010
	Physici	an	Decedent's Name (First, Middle, Last)	[ ]	7		2. Date of Death Month Da	y Year	3. Time of Death
	/Medio		James E.	rora:	>r		MARCH 10		21:15 M
	Examir	er	4a. Facility Name (If not institution, give s	treet and number) 4L HOSPITM	7/_ 4b.	City, Town, or Location of Deal	2	County of Death	
	Funeral		5. Social Security Number 6. Sex			Under 1 Year If Under 24 Hrs nths Days Hours Min.		9. Birthp	lace (State or Foreign
b	Director		011-14-2120	M 20 F   84	Yrs.	nths Days Hours Min.	April 19,10	121 Vir	ainia
	and *		Usual Residence of Decedent  10a. State 10b. County	10c. C	ity, Town or Locatio	n		11	Od. Inside City Limits
	Aaryla f eho	ŏ	110	T	2 - 11			"	1 X Yes 2 □ No
	the 28a-	Funeral Director	Naryland V/7	T		O CO M. Zip Code	10g Ci	tizen of What Coun	trv?
	3a or	<u>a</u>	2707 Chat	ham Rd		21215		11 SA	,.
	death	ner	11. Marital Status	2. Was Decedent Ever in t		Decedent of Hispanic Origin? (5	Specify Yes or No-	14. Race - America	
9	or its		1 ☐ Never Married 2 Married	Armed Forces? 1 X Yes 2 ☐ No If Yes, Give		, specify Cuban, Mexican, Puèr ′es 2⊠ No <i>Specify:</i>	to Hican, etc.)	Black, White,	etc.
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Maryland	Menta Menta arkad	To	Floyd to	rd		Mar	y Jete	2r	
Nar	2 sh and is m		19a. Informant' Name/Relationship (Typ	oo, Print) (wife)	19b. Mailing Ad	dress Street an Number or Ri	urdi Route Number, City	or Town, State, Zip	Code)
	1 and 1ealth am 27 ther t		20a. Method of Disposition	rord	Place of Disposition	Chatham	Date 20c.	140, Ma	12/2/5
JO.	Pages nent of t int: if ite		1 Burial 2 ☐ Cremation 3 ☐ Re		gemetery cremator	or other place)	20c. L	ocation - City or To	wn, State
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importants if item 27 is marked other than "neturel", or itame 23a or 28a-f ehow may injury or other traumatic event, the Madical Experiment must be notified at once.		4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service Linese		100010W	ne and Address of Facility	12006 W	ocalar	un, Ma.
Ba	permit. I Departm importa eny inju		· Joseph	T. KI		eph L. Russ	Funeral	Home, P.	A:
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	the Ho in 24 the Fu pletel	edical	(Check only 2 Medical Examinone)	er: On the basis of examina and manner stated.	ation and/or investig	ation, in my opinion, death occu	rred at the time, date and	d place, and due to	the cause(s)
	To To E	Σ	29b. Signature and title of certifier	1 200		29c. License number	29d. Da	te signed (Month, D	Day, Year)
	104		> gefroser	/ /		111243894	6 T51 119	reh 10,	12006
	U		30. Name and address of person who con	npleted cause of death (Item RESCU , M	m 23a) (Type, Print)	AT 243894	1/4/ 1/00 2	TAI	
	Sta	e	31. Date filed (Month, Day, Year)	32 Registrar's Signa	ature	VIT TICTYUM	INL HUST	1112.	
	Registra		MAR 1 4 200	6 Rouses A	ature focal	,			

			1 - For State Registrar	State of Maryla		artment of H			giene Reg. No. 006	07619
	Physici /Medic		Decedent's Name (First, Middle, Last	ALICE E. F	FEEHELEY	,		2. Date of Dea		3. Time of Death P 12:30 M
	Examir		4a. Facility Name (If not institution, give Genesis Elderca			4b. City, Town, or Severna		Death	4c. County of De	
	Funeral Director		213-03-4927	х Эм 2 і 7. Age (In yr 97	rs. last birthday) 7 Yrs.	If Under 1 Year Months Days	If Under 24 Hours	Min. 8. Date of Birth (Month, Day Apr 7,	(, Year)	irthplace (State or Foreign Country) aryland
	Maryland f show	or	Usual Residence of Decedent  10a. State  10b. County  Maryland  Anne A		City, Town or Lo					10d. Inside City Limits 1 ☐ Yes 2 🔥 No
	with the I	i Director	10e. Street and Number 105 Third A			10f. Zip Code	061-36		10g. Citizen of What 6	Country?
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23e or 28e-f show any injury or other traumatic event, I'm Medical Examinar must be notified at once.	by Funerai	11. Marital Status  1 Never Married 2 Marned 3 Xidwidowed 4 Divorced	12. Was Decedent Ever in Armed Forces?  1 Yes 2 No If Yes, Give Year or Dates:	1	Was Decedent of Hi f Yes, specify Cuba 1 ☐ Yes 2 No	spanic Origin n, Mexican, F Specify:	n? (Specify Yes or No- Puerto Rican, etc.)	14. Race - An Black, Wt Specify:	nerican Indian, nite, etc. White
Maryland 21215-0036	s within 72 ho liene. r then "natur the Mudical I	Completed by	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0·12)	cation le completed)  College (1-4or 5+)	(Give	dent's Usual Occupa kind of work done of DO NOT use retired chine Open	luring most o	f working	16b. Kind of Busines	s/Industry
/land	uld be filed Mental Hyg trked other	To Be C	17. Father's Name (First, Middle, Last) Norvill	e W. McCarty				Name (First, Middle, ry Belle B		
	and 2 sho Balth and I n 27 is ma		19a. Informant's Name/Relationship (T) Nancy Gasiorowski	(Niece)	105	Third Ave		er Rural Route Number E., Glen Bi		
Baltimore,	Pages 1 ment of He ant: if iten ury or oth		20a. Method of Disposition  1 🔀 Burial 2 ☐ Cremation 3 ☐ I  4 ☐ Donation 5 ☐ Other (Specify,	Removal from State	edar Hi	natory or other place 11 Cemete	ry   3	/13/2006	20c. Location - City of Baltimore.	Maryland
Balt	permit. Depart Import sny inj		21. Signature of Funderal Service Licens	•• Kevin E E	cker 22	Name and Address ACCully-P 237 E. Pa	s of Facility Olynia tapsco	k Funeral Ave., Bal	Home, P.A. to., Md.	21225-1856
,8760,	Physician and physician and physician sipe prize the prize transit.	dicai Examiner	23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	ne cause on each line.	equence of):	,	g, such as ca	rdiac or respiratory arr	est,	Approximate interval Between Onset and Death
P.O. Box 68	that the death certifical ed by the at ending phi detached for use as th	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 MNo 9 □ Unknown	23c. If yes, outcome of preg 1 Live birth 2 Fe 4 Pregnant at time of 9 Unknown	tal death 3	Ectopic pregnancy Other (specify)			23d. Date of d Month	elivery Day Year
rds, P.	quires that in signed by	þ	Part II. Other significant conditions co	ntributing to death but not re	esulting in the ur	nderlying cause give	n in Part I.			to lhe cause of death?  Probably 4 □Unknown
Vital Records,	ysician: The law requir is certificete has been si director, page 2 should	Completed						24a. Was a autops perfort	an 24b. Were a prior to death?	
Division of Vit	To the Hospitel or Attending Physician: The law requires that the death certificate be executed within 24 hours efter death.  To the Funerel Director: After this certificete has been signed by the at ending physician and completely filled in by the tuneral director, page 2 should be detached for use as the burial-transit	Certification: To Be	27. Manner of Death  1 Natural 5 Pending investigation  3 Suicide 6 Could not be	28a. Date of Injury (Month, Day Year)	home, farm, stre	28c. Injury Work M 1 🗆 Y	r: 4 X Nursi			
٥	lospitel or hours efte unerel Dir		29a. Certifier 1 Certifying Phy	building, etc. (Special sician: To the best of my kiner: On the basis of examination of the basis of examination of the basis of examination of the basis of examination of the basis of examination of the basis of examination of the basis of examination of the basis of examination of the basis of examination of the basis of examination of the basis of examination of the basis of examination of the basis of the basis of examination of the basis of the basis of the basis of the basis of examination of the basis of	nowledge, death	occurred at the tim	e, date and p	City or Town	ause(s) and manner	as stated.
	To the P within 24 To the F complete	Medical	one) 29b. Signature and Ittle of certifier	and manner stated.		29c. License	number	2	9d. Date signed (Mor	nth, Day, Year)
,	6		30. Name and address of person who co		em 23a) (Type,	Print) V	1136	RIRE	1 ARCH	12,2006 MD 21236
100 mg	Sta Registr		31. Date filed (Month, Day, Year)  MAR 1 4 2006	FICACE MI 32. Registrar's Sign	nature	2 HILBI	KINE	INU, BAL	I IMIURE	(V) 2(4)6

				1- State of Maryland / Department of Health Certificate of Death		Hygiene Rag. No.	)06	07620
_	*	Physici		1. Decedent's Name (First, Middle, Last)  Robert Allen Finton	2. Date Mont	of Death	ď	3. Time of Death / 300 P M
		/Medic Examir		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location			ounty of Death	
	5	The State of		Upper Chesapeake Medical Center Bel Air			Harford	
	**	Funeral Director		213-62-7088 1X M 2□F 47 Yrs. Months Days Hours	Min. 8. Date (Mont	h, Day, Year)	Cour	lace (State or Foreign try) yland
		and		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location			1	0d. Inside City Limits
		Mary infeh	ţō	Maryland Harford Joppa				1 ☐ Yes 2 No
		th the	lrec	10e. Street and Number 10f. Zip Code		10g. Citize	on of What Cour	itry?
Pm		23a c	raic	87 Haverhill Road 21085		USA		
		ltems	nue	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Never Married 2 ★ Married  1 □ ★ S 2 □ No	rigin? (Specify Yes o in, Puerto Rican, etc	or No- 14	Race - Amend Black, White,	
300	21215-0036	72 hours after death with the Maryland netural', or Items 23a or 28s-f show Stal Exantinet must be notified at	Completed by Funeral Director	1 □ Never Married 2 □ Married 1 □ Myes 2 □ No If Yes, Give 1 □ Yes 2 □ Mo Specify Year or Dates: 1979-85	r.	S	pecify: Whi	te
3	Š Č	72 ho	eted	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of work done during mos	st of working	16b. Kind	of Business/Inc	
-	121	within ene. then	mpie	Elementary/Secondary (0-12) College (1-4or 5+) life. DO NOT use retired)	S. O. Working	T 6 -		h 1 d
		e filed val Hygie other t	ပိ	4 Educator  17. Father's Name (First, Middle, Last)  18. Moth	ner's Name (First, M			ucation
٥.	a	ould be Mental wrked o	To Be	Allen Lester Schultheis Jo	Anne		erson	
	Maryland	and and and	-	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Numb	per or Rural Route N	umber, City or	Town, State, Zip	Code)
	-	1 and 2 Health tem 27 t		Jeannine L. Finton - Wife 87 Haverbill Road,	JoppaM	aryland	21085	
3/8	و	ages 1 of H or of H or ot		20a. Method of Disposition  1 □ Burial 2 □ Cremation 3 □ Removal from State  20b. Place of Disposition (Name of cemetary, crematory or other place)	Date 2		ition - City or To	_
∾ :	Baltimore	permit. Pages 1 an Department of Heal Important: If item 2 eny injury or other ance.		4 Donation 5 Other (Specify) Hilltop Service Corp.  21. Signature / Funeral Service Licensete // 22. Name and Address of Facility		Tows as Fune	on, Mar	
(	g E	Depa Impo eny li		Mullell may 1317 Cokesbury	Road, Ab	ingdon,		•
_				23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as shock, or heart failure. List only one cause on each line.				Approximate Interval Between Onset and Death
		Priysiciai /Medical		Immediate Cause (Final disease or condition resulting in death)  a. METASTATIC ESOPHAGEAL	CANCE	R	1	MONTH
4		Examiner		Due to (or as a consequence of):				
24	-		ner	Sequentially list conditions, if any, leading to immediate cause. Fine I Indertying.  Due to (or as a consequence of):				
表	K	executed in and ial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):				
80045249A	60,	ficate be executed physician and s the burial-transit		Due to (or as a consequence of):				
7	<b>68/6</b> 0,	ficate be physicia sthe bur	edicai	d				
-	×	eath certif attending for use a	In/M	IF FEMALE: 23b. Was decedent pregnant in the part 13 march 2  23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy		23	d. Date of delive	ry
X;	מ	res that the death cenigned by the attendin be detached for use	Physician/M	1 Yes 2 No 4 Pregnant at time of death 5 Other (specify)		_	Month	Day Year
, ,	<u>7</u>	that the	Phy	9 ☐ Unknown  Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part	23e	Did tobacco use	contribute to th	e cause of death?
+	ďŠ,	- W 73	d by	g coloning and and and an and an and an analysis		1 ☐ Yes 2 D	-	abiy 4 □Unknown
3	Ö	sician: The law requir certificate has been si rector, page 2 should I	Completed		24a.	Was an	24b. Were auto	osy findings available
0	Ĕ	The la ate ha page 2	mo		1 D Y	autopsy performed?	prior to cor death? 1 \( \text{Yes}	npletion of cause of
$\alpha$	<u> </u>	cian: ertifica sctor, I	Bec	examiner:	e of Death (Check of	-		
	5	Physic this o	2	1 Yes 2 No Hospital: Inpatient 2 ER/Outpatient 3 DOA Other: 4 No	ursing Home 5			1)
For	_ _ 0	ding F h. After funera	tlon	27. Manner of Death  1 Natural 5 Pending (Month, Day Year)  2 Accident investigation  28a. Date of Injury 28b. Time of Injury 4 Work?  1 Yes 2		ribe how injury	occurred	
+	Division of Vital Records	Attendir death ector: A by the fi	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office	28f. Locat	ion (Street and	Number or Rura	l Route Number,
:	5	tal or	Cert	4 Homicide building, etc. (Specify)	City o	r Town, State)		
L		To the Hospital or Attending Physician: The la within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medical	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, death occurred at the time, date an analysis of examination and/or investigation, in my opinion, death occurred at the time, date and manner stated.	nd place, and due to ath occurred at the t	the cause(s) a ime, date and p	nd manner as st lace, and due to	ated. the cause(s)
		To the To the Complet	Me	29b. Signature and little of certifier 29c. License number		29d. Date	signed (Month, i	Day, Year)
		141		> XMMMY Mann H410	69	MAR	CH 9	2006
		257		20 Name and address of person who completed cause of death (Item 23a) (Type, Print)  DK STANLEY KWAN 1308 BUSINESS CH		daei	(coc)	21040
		Sta		31. Date filed (Month, Day, Year)  32. Redistrar's Signature		-100		. 10
	A.	Registr	ar	MAR 1 4 2006 Pages 25° Agree				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend item#14,perrff (853.3/21/06 TT State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 352 Farmer narles 2006 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Bultimore Medical University Center Maryland If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Hours Months Days 10 M 2□ F So. Carolina 60 Nov 10, 1945 Director 250-76-8723 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or itame 23e or 28e-f show any injury or other treumatic event, the Modical Examinar must be notified and page. 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location 1 Yes 2 No **Baltimore** N/A Director Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 21223 1043 West Fayette Street by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White etc. 1 Never Married 2 ☐ Marned Baltimore, Maryland 21215-0036 1 Yes 2 X No Yes. Give Specify: Specify. White If Yes, Give Year or Dates: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Self Employed Construction 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Rosa Farmer Unk 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1043 West Fayette Street Baltimore, Maryland 21223 Connie Epps Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 3 Removal from State 1 Burial 2 Cremation 03/13/06 Catonsville, Maryland 4 □ Donation 5 □ Other (Specky) Metro Crematory, Inc. 21. Signature of Funeral Service Cicens 22. Name and Address of Facility Estep Brothers Funeral Service, P. 1300 Eutaw Place Baltimore, Md 21217 Approximate Interval Between Onset and Death Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each lin cations that caused Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) cranial **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-transit the attending physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy Month Year in the past 12 months? Day 4□Pregnant at time of death 5 Other (specify) be detached 9 Unknown has been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>م</u> 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performe this certificate 1 ☐ Yes or Attanding Physicien: 26. Place of Death (Check only on funeral director, 25. Was case referred to medical Be ner' examiner 1 Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1X Inpatient Certification: To 2 No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Natural Injury within 24 hours after co...
To the Funeral Director: After 5 Pending 1 Yes 2 No investigation 2 Accident 6 Could not be determined 3 T Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License numbe 29b. Signature and to who completed cause of death (Item 23a) (Type, Print) Greene Street Balto. 2 alaunda M. South Thomas 32 Registrar's Signature 31. Date filed (Month, Day, Year) State South Registrar

DHMH 17 Rev 1/2001

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		1 - For State Registrar		State o	f Marylar		artmer <i>rtificat</i>				lental Hyg	giene Reg. No. 0 (	16	07622
Physic	cian	Decedent's Nar									2. Date of Dea Month	Day	Year	3. Time of Death 12:40a M
/Mec	lical			CHARD FEI			45 035	Taura	Landing	of Dooth	MARCH	9, 20		
Exam	iner	4a. Facility Name GILCH		n, give street and nur	nber)		1	OWS	Location	of Death		4c. County	TIM(	
Funera		5. Social Security		6. Sex	7. Age (In yrs.	last birthday	If Under	1 Year	If Under	24 Hrs.	8. Date of Birtl	h	9. Birth	npface (State or Foreign
Directo		219-28-		1 XM 2 ☐ F	74	Yrs.	Months	Days	Hours	Min. (	CTonth 25	7931	MΪ́	HIGAN
and		Usual Residence	of Decedent 10b. County		10c. Ci	ty, Town or L	ocation							10d. Inside City Limits
Maryland I-f show	ţ	MD	BALTI	MORE	MO	NKTON								1 ☐ Yes 2 🛣 No
3a or 28a	Funeral Director	10e. Street and N 601 CO	RBETT	ROAD			10f. Zip	Code 111	1			10g. Citizen of USA	What Co	untry?
natural, or iteme 23a or 28a-f show	ρ	_	rried 2 X Mar 4 □ Divorced	Armed Fo	edent Ever in Urces? 2 No 6 KORE	J.S. 13.	Was Dece ff Yes, spe		ispanic Or in, Mexical Specify:		ecify Yes or No- Rican, etc.)	Bla	ce - Amer ck, White y: WH	
"natural"	Completed	(Spe	15. Deceden	it's Education st grade completed)		16a. Dece	dent's Usu kind of wo DO NOT u	al Occup	ation	st of work	ing	16b. Kind of B	usiness/l	ndustry
	ď	Efementary/Sec		College (1	1-4or 5+)		ANIC				-	AEROS	PACI	<b>ਜ</b> ਼
ther.	ပိ	17. Father's Name	e (First, Middle,			11201					e (First, Middle,			
ic eve	To Be	WILLIA									HY KINO			
er traumat		19a. Informant's I			aughte		ng Address	BET'	and Numb	er or Rur. • MO	al Route Numbe	r, City or Town, MD 2	, State, Z 111	iip Code) L
Important: if item 27 is marked other then eny injury or other traumatic event, the Monda				3 □Removal from Specify)	Ctata	Place of Disp cemetery, cre LANEY	matory or o	ither plac	:ө)		Date 4/2006	TIMON	-	
eny inj		21. Signature of F	uneral service	Licensee A G	0	2	2. Name ar 1692	d Addres	ss of Facili	HEIRD.	NRY W. MONKTO	JENKI ON, MD	NS 8	s sons co.
iciar dica		23a. Part1. Enter shock, or he Immediate Cause disease or condit resulting in death	eart failure. List e (Final ion	r complications that of only one cause on e	ach line.	tag	2 0	ive	hs-	lic	Livera		e	Approximate Interval Between Onset and Death MMTM
ine		Sequentially list of any, leading to	conditions, immediate	b. Ac	or as a conse	in	one	he	PAT	1.71	Š			years
ysicien and ne burial-transit	cal Examiner	Sequentially list of any, leading to cause. Enter Uno Cause (Disease of that initiated even resulting in death	perinjing or injury its ) Last	c Due to	(or as a consec	quence of):					·			0
ed by the attending physi detached for use as the l	Physician/Medi	IF FEMALE: 23b. Was decede in the past 1 1  Yes 2 9  Unknow	2 months? ! □ No		oirth 2 ☐ Feta nant at time of	af death 3	⊒Ectopic p ⊒ Other (s)		,				ite of deli	very Day Year
8	۵	Part II. Other sign	nificant conditi	ons contributing to d	eath but not re	sulting in the	underlying	ause giv	en in Part I	l.	23e. Did to	1.		the cause of death?
page 2 should I	Completed										24a. Was autop perior	sy med?	prior to death?	topsy findings available completion of cause of
s certificete has b lirector, page 2 s	Be C	25. Was case refe	erred to medica	d					26. Place	e of Deat	1 ☐ Yes h (Check only o		10 165	2 No
fter this	10		5 🗌 Pendir	28a. Date	Inpatient 2 of Injury th, Day Year)	28b. Time of Injury		8c. Injun Wor	4 🗆 N		ome 5 Resid	- + +	ner <i>(Spe</i> d rred	Hospia
To the Funeral Director: Alter completely filled in by the funer	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 □Could determ	nined   286. Place	of Injury - At h		reet, factor	y, office			28f. Location (S City or Tow	Street and Numb m, State)	ber or Ru	ral Route Number,
To the Funeral Director: A completely filled in by the fu	Medical	29a. Certifier (Check only one)	1 Certifyii 2 ☐ Medical	ng Physician: To the Examiner: On the b and man	best of my kn asis of examin ner stated.	owledge, dea ation and/or i	th occurred nvestigation	at the tin	ne, date ar pinion, dea	nd place, ath occur	and due to the or red at the time, or	cause(s) and m date and place,	anner as and due	stated. to the cause(s)
COM	2	29b. Signature an	An	hoy K	ile	·	0	-	e number	كال		29d. Date signe		9,2006 12,206
,+  s	tate	30. Name and ad	7. R.J	Ry 6 B.	se of death (fle	5701	Print) N- (	ho	ule	» S7	t. Bo	elts.	MN	2120/6
Regis	trar		MAR 1	4 2006	a a	N. A.	Costs	,						
						ORIG	INAL							

State of Maryland / Department of Health and Mental Hygiene Certificate of Death

2. Date of Death

Month

3. Time of Death

Year

TIMONIUM

2006

2006

FITZPATRICK, VINCENT

Division of Vital Records,

**Physician** 

1. Decedent's Name (First, Middle, Last)

cal	VINCENT dePA	UL FITZPATRICK,	Jr.		March 8	, 2006	8:50 P. M	
	4a. Facility Name (If not institution, give			or Location of Dea	ath	4c. County of Death		
*	Stella Maris		Timo	onium		Baltimo	re	
700	Social Security Number     6. S		thday) If Under 1 Year Months Days	tf Under 24 Hr Hours Mir		9. Birth	place (State or Foreign intry)	
	215-16-2083	X <sup>™</sup> 2□F 85	Yrs.	riours iviii	March 24,	1920 Ma	ryland	
1	Usual Residence of Decedent	100 City Town			•		404 4-11-05-11-5	
ايا	10a. State 10b. County	10c. City, Tow	n or Location				10d. tnside City Limits	
Director	Maryland Baltim	ore Timor	nium			1 ☐ Yes 21X N		
	10e. Street and Number		10f. Zip Code		10g.	Citizen of What Cou	intry?	
a	2525 Pot Spring l	Road		21093		U.S.A.		
Funeral	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of If Yes, specify Cut	Hispanic Origin? (	Specify Yes or No-	14. Race - Amer Black, White		
2	1 Never Married 2 Married	1 X Yes 2 □ No			ito moati, etc.)		, etc.	
2	3 X Widowed 4 ☐ Divorced	Year or Dates:1946-47	1 ☐ Yes 2 X No	Specify:		Specify: Wh	ite	
2	15. Decedent's Ed (Specify only highest gra	ducation 16a.	Decedent's Usual Occu (Give kind of work done	pation	16b.	Kind of Business/I	ndustry	
Сотрыетеа	Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO NOT use retire	ed)	orking			
		5+ 0	bstetrician	/Gynecol	ogist	Medica	al	
	17. Father's Name (First, Middle, Last)			18. Mother's Na	ame (First, Middle, Maid	len Sumame)		
o Re	Vincent dePaul F	itzpatrick		Mary	Anita O'Co	nor		
	19a. Informant's Name/Relationship (		. Mailing Address (Stree		Rural Route Number, Cit		p Code)	
		l a c			son, Maryla			
1/2	J. Lawrence Fitzp  20a. Method of Disposition		Disposition (Name of	Ave. Iow		and 21204 Location - City or T		
	1 X Burial 2 ☐ Cremation 3 ☐	Removal from State cemeter	ry, crematory or other pla					
,	4 □Donation 5 □Other (Specify		athedral Ce	netery :	3-13-06 Ba	ltimore,	Maryland	
	21. Signature of Funeral Service Licer	S <del>00</del>	Mitchell-	ess of Eacility	d Funeral H Baltimore, 1	ome Inc		
İ	23a. Part 1. Enter the disease, or com	hane	6500 Yorl	k Road	Baltimore.	Marvland	21212	
Calphiedical Examine	resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Pue to (or as a consequence  Due to (or as a consequence  c. Due to (or as a consequence  d.	ral lobe	ntracer	ebral hem	ormage	weeks	
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑No 9 □ Unknown	23c. If yes, outcome of pregnancy 1 \( \subseteq \text{Live birth} \) 2 \( \subseteq \text{Fetal death} \) 4 \( \subseteq \text{Pregnant at time of death} \) 9 \( \subseteq \text{Unknown} \)	3 □Ectopic pregnand 5 □ Other (specify) _			23d. Date of delia	very Day Year	
5	Part II. Other significant conditions c	ontributing to death but not resulting in	n the underlying cause gr	ven in Part I.	23e. Did tobacc	o use contribute to	the cause of death?	
2					1 □ Yes	2 <b>X</b> No 3 □ Pro	bably 4 Unknown	
				·				
duo					24a. Was an autopsy performed:	prior to co	opsy findings available ompletion of cause of 2 No	
מ	25. Was case referred to medical examiner?				eath Check only one			
ļ	1 ☐ Yes 25 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Ou	itpatient 3 DOA	her: 4 Nursing	Home 5 Residence	6 ☐Other (Spec	fy)	
1	27. Manner of Death  1 Ratural 5 Pending 2 Accident investigation	(Month, Day Year) t		ry at ork? ] Yes 2 □ No	28d. Describe how in	itury occurred		
ertification	3 Suicide 6 Could not be determined	28e. Ptace of Injury - At home, fa building, etc. (Specify)	rm, street, factory, office		28f. Location (Street City or Town, Sta	and Number or Rui ate)	al Route Number,	
Medical	29a. Certifier (Check only one)  1 Certifying Ph 2 Medical Exam	ysician: To the best of my knowledge ilner: On the basis of examination an and manner stated.	e, death occurred at the t d/or investigation, in my	ime, date and plac opinion, death occ	ce, and due to the cause curred at the time, date a	(s) and manner as and place, and due	stated. to the cause(s)	
Ž	29b. Signature and title of certifier	In Ingles as	_   _	se number	00	Date signed (Month	Day, Year)	

Registrar

DULINEY VALLEY ROAD

2300

32. Registrar's Signature

30. Name and address of person who completed cause of death (ttem 23a) (Type, Print)

ERNESTINE WRIGHT,

MAR 1 4 2006

31. Date filed (Month, Day, Year)

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene | | | For State Registra Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 8:25 A M March 9, 2006 Marian Joyce Goodman 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Anne Arundel Anne Arundel Medical Center Annapolis If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) 12/09/1954 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex 1 ☐ M 2 🛣 F 219-62-2747 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 1 ☐ Yes 2 X No Pasadena MD Anne Arundel 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 287 Cove Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify: White 3 X Widowed 4 □ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Department of College (1-4or 5+) Elementary/Secondary (0-12) Aging Case Manager 18. Mother's Name (First, Middle, Maiden Sumame) 17 Father's Name (First, Middle, Last) Inez Louise Price Joseph Matthew Jindra 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 941 Aqua Court, Annapolis, MD 21401 Jason Goodman / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Bayview Crematory 03/14/06 Baltimore, 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility G. J. Gonce Funeral Home, 21. Signature of Funeral Service Cicensee 169 Riviera Drive, Pasadena, MD 21122 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death lung concer Von Smal /uh disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 🗷 No 9 ☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 1 No 3 Probably 4 Unknown neymouse 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 ☐ No 12 Yes 26. Place of Death (Check only one) 25. Was case referred to medical examiner?

Physician /Medical **Examiner** 

**Physician** 

/Medical

Examiner

**Funeral** 

Director

28a-f show

Items 23a

5

"natural",

and Mental Hygiene. Is marked other than

item 27

ō Department of Importent: If any injury or once.

other treumatic event, the Medical Examinar must be notified at

Completed by Funeral Director

Be

the Maryland

With ō

Pages 1 and 2 should be filed within 72 hours after death

Baltimore, Maryland 21215-0036

Box 68760.

P.O.

Records,

Division of Vital

Physician/Medical Examiner burial-transit the t 0 by Completed Be Ě 2 Certification;

The law requires that the death certificate be executed the has To the Hospital or Attanding Physician: Inis After after death.

within 24 hours a

To the Funerel C State

Medical 29b. Signature and title of certifier

1 Yes 2 No

27. Manner of Death

1 Death

2 Latural

2 Laccident

3 Suicide

29a Certifier

4 Homicide

Peterson Robert 31. Date filed (Month Day Year)

Hospital:

28a. Date of Injury (Month, Day 5 Pending investigation 6 ☐ Could not be

1 Inpatient 2 ER/Outpatient 3 DOA

MD

28b. Time of

28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number

Anneply und 21401

D24804

1 ☐ Yes 2 ☐ No

28c. Injury at Work?

03-08-2006

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

determined

DHMH 17 Rev 1/2001

Registrar

			State of Maryland / Department		Reg	. No. 0 0 6	07625
Ź	Physicia /Medic	_	1. Decedent's Name (First, Middle, Last)  Philip William Green		2. Date of Death Month March 6	, <sup>Da</sup> 2006 <sup>Year</sup>	3. Time of Death 3:30 p M
Table 1	Examin		4a. Facility Name (If not institution, give street and number) 1803 Blakefield Circle	4b. City, Town, or Location of Death Lutherville		4c. County of Death Baltimo	re
	Funeral Director		5. Social Security <b>6836</b> 218-26-9 <del>493</del> 6. Sex 1 N 2 F 7. Age (In yrs. last birthday) 74 Yrs.	If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth June 25,	9. Birthp	lace (State or Foreign Ito) 'Iand
7	ehow	or	Usual Residence of Decedent	ocation herville		1	0d. Inside City Limits 1 ☐ Yes 2 No
	with the h	I Director	10e. Street and Number 1803 Blakefield Circle	10f. Zip Code 21093	10	g. Citizen of What Cour	ntry?
920	be filed within 72 hours after death with the Maryland tall Hygiene.  dother than "natural", or Iteme 23a or 28a-f ehow event, Ira Medical Examinat must be notified a	by Funeral	Armed Forces?  1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No	Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ★ No Specify:	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White, Specify: Whi	etc.
Maryland 21215-0036	a within 72 hou piene. r than "naturallia healing"	Completed	(Specify only highest grade completed) (Give	dent's Usual Occupation kind of work done during most of worki DO NOT use retired) UPANCE AGENCY	ng	6b. Kind of Business/Inc	dustry ed/Insurance
/land	2 should be filed vand Mental Hygie is marked other transmitted other sumatic event, III.	To Be C	17. Father's Name (First, Middle, Last) Philip Weisner Green	18. Mother's Name	(First, Middle, Ma	aiden Sumame) Banz	
	s 1 and 2 should of Health and Men Item 27 is marke other traumatic			ng Address (Street and Number or Rura Blakefield Cir.,	Luthervi		Code) 093
Baltimore,			4 Donation 5 Other (Specify)	matory or other place) Serv. Corp 3/9/	06	Towson, N	1D
Balt	permit. Page Department of Important: If eny Injury or		· Mull	2. Name and Address of Facility Ruc 1050 York Rd., Tow	son, MD	21 204	ome, Inc.
	Physician /Medical Examiner	Examiner	23a. Part1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition: resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events  C.	Paucucatio			Approximate Interval Between Onset and Death  UN HU
P.O. Box 68760,	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Medical Ex		□Ectopic pregnancy □ Other (specify)		23d. Date of deliver	ery Day Year
	equires tha en signed ould be de	þ	Part II. Other significant conditions contributing to death but not resulting in the u	inderlying cause given in Part I.	23e. Did toba	acco use contribute to the 2 No 3 Prot	
Vital Records,		e Completed	25. Was case referred to medical	26. Place of Death		ed? prior to co death? No 1 ☐ Yes	psy findings available mpletion of cause of
ō	ng Physici fter this ce ineral direc	ToB	examiner?  1	nt 3 DOA Other: 4 Nursing Ho		nce 6 □Other (Specit	y)
Division	a # F =	Certification;	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)	reet, factory, office	28f. Location (Stre City or Town,	eet and Number or Rura State)	al Route Number,
	To the Hospital within 24 hours a To the Funerel I completely filled	Medical	Check only one)    Check one)    C	nvestigation, in my opinion, death occurr	ed at the time, da	te and place, and due to	the cause(s)
	T T T T T T T T T T T T T T T T T T T	Σ	29b. Signature and the organization of the signature and the signa	29c. License number D1 31 90	29	d. Date signed (Month,	Day, Year)
	10th			ne St., #7143, Bal	timore,	MD 21207	
1	Sta Registi		31. Date filed (Month, Day, Year)  MAR 1 4 2006	whi.			

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Ε. GILLETTE VILMA 08:00 ам MARCH 13, 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Baltimore 4c. County of Death Baltimore Examiner 6503 MAPLEWOOD ROAD If Under 1 Year If Under 24 Hrs. 8. Date of Birth FeD. 17, 1935 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign 125-26-1226 Days Hours 1 M 2 X F 71 Newryork Director Usual Residence of Decedent 10a State 10c. City, Town or Location 10b County 10d. Inside City Limits or 28a-f show other treumatic event, the Medical Exeminer must be notified at 1 TYes 2 No Director Baltimore Baltimore the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6503 Maplewood Rd. 21212 USA Iteme 23a death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "natural", or Iten eny injury or other treumatic event, Ite Medical Exerting. Once. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No White Completed by Specify 3 □ Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Administrator Baltimore County 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Adolph Kozatiwitz Vera Rezanka 0 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6503 Maplewood Rd. Baltimore, Md. 21212 Mr. Alfred Gillette/ Husband 20b. Place of Disposition (Name of cemetery, crematory or other p 20a. Method of Disposition Date 20c. Location - City or Town, State Hilltop Service Co. 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 3-14-06 Towson, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 1050 YORK ROAD (R. G.RUTH) RUCK TOWSON FUNERAL HOME, INC. TOWSON, MD. 21204 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner ere brongscular Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) The law requires that the death certificate be executed attending physicien and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes XX No Month Day Year 4□Pregnant at time of death 5 Other (specify) been signed by the should be detached 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an certificate has birector, page 2 s autopsy performed? Yes XIX No 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death | Check only one Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 XX Residence 6 Other (Specify) ٥ 1 ☐ Yes X No this After thi 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Medical Certification: 28d. Describe how injury occurred 5 Pending investigation X Natural death. 1 Yes 2 No 2 Accident nerel Director: A 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) To the Hospitel or At within 24 hours after of To the Funerel Direct 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MO 57444 MARCH 13, 2006 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Chen Woodbine Ter, Towson, MD Alexander 603 32. Registrar's Signature 31. Date filed (Month, Day, Year) State MAR 1 4 2006

Registrar

		•	For State Registrar	State of I	Maryland	•		of Healt		lental Hygi	ene (	96	07627
			Decedent's Name (First, Middle, L.	ast)						2. Date of Death		Veer	3. Time of Death
	Physicia /Medic		Wendell L	isbon Gl	ladden					March	fr,	2 <b>00</b> 6	10:20a™
	Examin		4a. Facility Name (If not institution, gi					own, or Locat				y of Death	
			Maryland Maso			think to V	If Under 1		svill nder 24 Hrs.	0. D. t 4 Dist.		timo	C E lace (State or Foreign
	Funeral Director		5. Social Security Number 4.91-05-2815	Sex 1 TM 2 □ F	Age (In yrs. la 88	Yrs.		Days Hou		May 6,	1917	Count	LSSouri
	P.		Usual Residence of Decedent										0d. Inside City Limits
	arylar ehow	_	MD Howa	rd	10c. City,	Town or Lo Sykes		e				'	1 ☐ Yes 2 🛣 No
	89-f	ecto				Dy RCC	10f. Zip (			10	g. Citizen of	What Cour	
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene Importent: if item 27 is marked other than "naturel", or Iteme 23a or 28e-f ehow amy injury or other treumatic event, I'm Medical Examinational tempitied at ances.	Funeral Director	10e. Street and Number 1460 Coventry	Meadows	s Driv	e	Tor. Zip C	21784			-	SA	iu y :
	death	Jera	11. Marital Status	12. Was Decede	ent Ever in U.S	i. 13. V	Vas Decede	ent of Hispanie	c Origin? (Spe xican, Puerto	ecify Yes or No-		ce - Americ	
Q	after or Ite	Fu	1 ☐ Never Married 2 ☐ Married				1 ☐ Yes 2			riioari, etc.)		y:Whit	
3	urel',	d by	3 Widowed 4 □ Divorced	Year or Date	9S:			Occupation		1 ,	6b. Kind of B		
ç	n 72 nat	lete	15. Decedent's l (Specify only highest g	rade completed)		(Give	kind of work	done during	most of work	ing	OD. KING OF E	003111033/1111	30311 <i>y</i>
7	iene.	Completed	Elementary/Secondary (0-12)	College (1-4	or 5+)	Wa	atchm	aker			Jewe:	1ry	
2	e filec al Hyg othe vent,	Be C	17. Father's Name (First, Middle, Las					18. M		e (First, Middle, M			
<u>a</u>	Menta	70	Donald R.							ne B. N			01701
baitimore, maryland z i z i 3-0036	2 short and is mu	4	19a. Informant's Name/Relationship			1190. Mailir	ng Address	Street and No	umberorRum Mead	al Route Number, .ows Dr	City or Town	, State, Zip PSV1	Code)21/84 11e MD
e` •	1 and Health sm 27 ther t	1	Mrs. Patricia  20a Method of Disposition	Schindne				and the same of th		2 C 2 C 2	Oc. Location		
0	ages nt of h i: ff ite		1 Burial 2 Cremation 3		ale	ace of Dispo metery, cren		oleum	3/14/				lle, MD
	artme orteni injury	1	* 4 □ Donation 5 □ Other (Spec 21. Signature of Funeral Service Lic		nt   Cre					E & CHAP			
מ	Per Imp any		Dian K	Harse	+					84 (410)			
			23a. Part1. Enter the disease, or co shock, or heart failure. List on	mplications that cau	used the death.								Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	_	PATRIC		Diam	-	ty				Onset and Death
	/Medical Examiner		resulting in death)		as a consequ			/-/					
	Examiner	_	Sequentially list conditions,	b. — Due to (a)	r as a consequ	anan of\:							
1	ted nsit	nlne	it any, leading to immediate cause. Enter Underlying Cause (Disease or injury	D <b>ue</b> 10 (01	as a consequ	B1100 01).							
	al-trai	Examiner	that initiated events resulting in death) Last	CDue to (or	r as a consequ	ence of):							
8/60,	cate be executed physician and the burial-transit	dical		d									
9	rtificat ng phy as th	Medi	IF FEMALE.										
ž	th cer tendir or use	an/h	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outco 1□Live birt	ome of pregnar th 2 🗌 Fetal	death 3	Ectopic pre					ate of delive	ery Day Year
	The law requires that the death certificate has been signed by the attending tage 2 should be detached for use as	Completed by Physician/Me	1 Yes 2 No	4□Pregnar 9□ Unknow	nt at time of de vn	ath 5	Other (spe	cify)					
э. Э	that the ed by detac	Ph	Part II. Other significant conditions	contributing to dea	th but not resu	lting in the u	nderlying ca	use given in F	Part I.	23e. Did tob	acco use cor	ntribute to t	he cause of death?
ďŠ	uires sign Id be	d b	A Tresclata Vasas	en Disec.	u, con	poten	e Hee	ut Fa	ulne,	1 □ Ye	s 2□No	3 🗆 Prot	pabiy 4XUnknown
Vital Records,	w req beer shou	lete	Stude Cout A	trailfu	Property	Ch	nich	anal	an-	24a. Was ar		Were auto	psy findings available
e E	sician: The law scertificate has b lirector, page 2 s	E O	Auller Dry	120001-00	Justico V	1				autops perform 1 ☐ Yes 2		death?	mpletion of cause of
<u>ra</u>	an: Trifical	a	25. Was case retarted to medical					26. 1	Place of Deat	h (Check only on			
	Physician: this certific ral director,	ToB	examiner? 1 ☐ Yes 2XX No	Hospital: 1 ☐ Ing	oatient 2 🗆 B	ER/Outpatier	nt 3 DO	Other: 4	Nursing Ho	me 5 Reside			<b>5</b> y)
DIVISION OF	ng Pt Iter th	on:	27. Manner of Death  1 ★ Natural 5 □ Pending	28a. Date of (Month,	Injury Day Year)	28b. Time o Injury		dc. Injury at Work?	a. 17.11	28d. Describe ho	w injury occu	irred	
<u> </u>	Attending it death. ector: After by the fune	catl	2 ☐ Accident investigat 3 ☐ Suicide 6 ☐ Could not	t he	Claires At ha		M	1 Tes	2 🗆 NO	28f. Location (Str	eet and Num	her or Rur	al Route Number
<u> </u>	or At after of Direct in by	Certification:	4 Homicide determine	280. Place 0	of Injury - At hor g, etc. <i>(Specify</i>	me, rarm, str	reet, ractory,	office		City or Town	State)	1007 07 71070	ar riodio ivambor,
_	spitel ours ( nerel   filled			Physician: To the b									
	To the Hospitel or Attending Physician: The Is within 24 hours after death.  To the Funerel Director: Atter this certificate ha completely filled in by the funeral director, page.	edical		teminer: On the bas and manne		ion and/or in	vestigation,	in my opinion	, death occur				
	To the within To the Comp	ž	29b. Signature and title of certifier	۵			29c.	License num	iber	29	d. Date sign		Day, Year)
}	· 0		R.t. Juli	et, ms.	,			17160	64		3/13	106	
	0		30. Name and address of person wh	no completed cause	of death (Item	23a) (Type,	Print)	Roll	0. N	W 212	24		
	~		ROBERT LIBET 31. Date filed (Month, Day, Year)	32. Re	of death (Item	ure de la	2 11	our	v. / V	7 - 10	V- /		
	Sta Regist		MAR 1 4 200	6 Braces	B.	4700484							

			1 - For State Registrar	State of Ma	aryland /		artmer rtifica					Reg. No	11116	07	528
П	Physici	an	1. Decedent's Name (First, Middle, La	st)	H	10	KS				2. Date of D Month	Da	•		ne of Death
1	/Medio		4a. Facility Name (If not institution, giv	re street and number)			Ť		Location o		March 6		6 . County of Dea		:00 a M
4	Examili		16112 Malcolm Drive				La	urel				Р	rince Geo	rge's	
	Funeral Director		5. Social Security Number 6. S 204-03~4871	Sex 7. Ag 1 □ M 2 <b>X</b> □ F	e (In yrs. last 91	birthday Yrs.	If Unde Months	r 1 Year Days	II Under a	Min.	B. Date of Bi (Month, D	ay, Year)		thplace (St ountry) isylvan	ate or Foreign
	D		Usual Residence of Decedent								Jg. 5	1217	Tem		
	darylar f ehov	or	Maryland Prince Geo	orga!s	10c. City, To	own or L	ocation								de City Limits Yes 2 ☐ No
	r 28a-	rect	10e. Street and Number	orge s	Laurer		10f. Zij	p Code				10g. Ci	tizen of What C	ountry?	
	th with	ai D	16112 Malcolm Drive				20	707				Unite	d State A	merica	
36	is 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene.  Item 27 is marked other then "naturel", or Iteme 23a or 28a-f ehow other traumatic event, the Medical Examirer is not be notified at	by Funeral Director	11. Marital Status  1 □ Never Married 2 □ Married  3 ☑ Widowed 4 □ Divorced	12. Was Decedent Armed Forces? 1 Yes 2 1 If Yes, Give Year or Dates:		13.	Was Dece II Yes, spe 1 Tyes	cify Cuba	ispanic Orig n, Mexican Specify:	gin? (Spec i, Puerto Ri	ify Yes or N ican, etc.)	0-	14. Race - Am Black, Wh Specify: Wh	te, etc.	ın,
21215-0036	72 hor	Completed	15. Decedent's E. (Specify only highest gra	ducation ade completed)	1	6a. Dece	dent's Usu	al Occupa	ation during most	t of working	7	16b. K	(ind of Business	/Industry	
121	within iene. then "	mple	Elementary/Secondary (0-12)	College (1-4or 5	5+)				during most )	. or morning	,		0 !!		
d 2	e filed value of Hygie other t		12 17. Father's Name (First, Middle, Last,	)			Homema	ker	18. Mothe	r's Name (	First, Middle	1	Own Home Sumame)		
ılan	should be nd Mental marked o	To Be	Joseph W. Rehn						Maude	e Cross	sley				
Maryland	2 shoul and Me is mari rsumati	i	19a. Informant's Name/Relationship (	,, ,			-						or Town, State,	Zip Code)	
ď,	is 1 and 2 of Health a Item 27 is other trau		Christopher Rehn/nep 20a. Method of Disposition	ohew	20b. Place	ol Disp	osition (Na	me of		Cente Da	er, low te		50 ocation - City o	Town, Sta	te
Baltimore,	permit. Pages 1 Department of H Important: if Ite any injury or ot		1 Burial 2 Cremation 3 4 Donation 5 Other (Specif		ceme	etery, cre	matory or a Nation	other plac	M	ar. 20	, 2006		ington, V		
altir	mit. F partme portar y injur		21. Signature of Funeral Service Licer		AC LITTLE					y Fled	ck Fune			rigini	<u> </u>
<u>~</u>	Depa Impo any is		1 Olgoandria	Posito	<b>∞</b>	7	601 Sa	ndy S	oring F	Road La	aurel,	Maryl	and 2070	7	
1.	Physician /Medical Examiner	niner	23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury)	one cause on each lin	eta a consequenc	& 7 ce ol):	. /	7_		-	uce				I Between and Death
68760,	es that the death certificate be executed igned by the ettending physician and be detached for use as the buriat-transit	edical Examiner	resulting in death) Last	c. Due to (or as	a consequen	ce of):						- 4			
P.O. Box	the death certific y the ettending pl ached for use as I	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal dea	ath 3	⊒Ectopic p ⊒ Other (s <sub>i</sub>						23d. Date of de Month	blivery Day	Year
	law requires that the as been signed by th 2 should be detache	þ	Part II. Other significant conditions of	contributing to death b	ut not resultin	g in the u	inderlying (	cause give	en in Part I.			4,	use contribute t		e of death? 4 ∐Unknown
Vital Records,	The ate h	Completed									24a. Was auto perf 1 🗆 Yes		prior to death?	completion	ngs available of cause of
Vits	Physician: Th this certificate rat director, pag	Be	25. Was case referred to medicat examiner?	Hospital:				Othe			Check only				
o	E = E	on: To	1 Yes 2 No  27. Manner ol Death 1 Natural 5 Pending	28a. Date of Inju (Month, Da		Outpatie b. Time o Injury		28c. Injury Work	er: 4 □ Nui ⁄at ⟨?		e 5 Res		6 ☐ Other (Spenry occurred	ecify)	
Division	or Atten fter deal lirector: in by the	Certification:	2 Accident Investigatio 3 Suicide 6 Could not b 4 Homicide determined	e Zea Place of Init	ury - At home c. (Specify)	, farm, st	M reet, factor		Yes 2 □ t		If. Location City or To		nd Number or F e)	lural Route	Number,
	e Hospital	edical C	29a. Certifier Certifying Pr (Check only one) 2 Medical Exam	nysician: To the best miner: On the basis of and manner sta	examination	dge, dea and/or it	th occurred ivestigation	at the tim	ne, date and pinion, deat	d place, an	d due to the	cause(s , date an	and manner a d place, and du	s stated. e to the cau	use(s)
	To th within To th comp	Me	29b. Signature and title of certifier		·		29	c. License	number			29d. Da	ate signed (Mon	th, Day, Ye	ar)
)	FOT		Swah	tice	ai'			D	004	341	17	08	mm	RCH	2006
•	) \		30. Name and address of person who SWATI m-	completed cause of d	eath (Item 23	a) (Type	Print)	H	Am B.	CA	KE C	TR.	FT. M	Eno	E, MD
	Sta Registr	-	31. Date liled (Month, Day, Year)	32. Engistra 2006	ar's Signature	6	back	B							20755

			1- For Americal Item Registrar	n State of N	dr.,G	853,03 Cel	rtificat	6dhi e of l	ealth a Death	nd Me	ental Hygi	ene g. No.2 0 0 (	5 0	1629		
П	Physici	an	Decedent's Name (First, Middle, Las								2. Date of Death Month Feb. 2	7 , Day 2006 Yea		e of Death :10 p <sub>M</sub>		
	/Medi	cal	Shirley Faye Ha:		el .		4h City	Tour or	L continu	Doath	reb. Z	4c. County of De		•10 PM		
Å	Examir	ıer	n e e e e e e e e e e e e e e e e e e e		7)		11/a	- 10wn, or	Location of			Baltimor				
f	Funeral		Gilcrest Hospic  5. Social Security Number 6. Se		ge (In yrs.	last birthday)	If Under		If Under 2	4 Hrs.	B. Date of Birth	Birth 9. Birthplace (State or Foreign				
	Director		217-54-4123	□M 21/2 F	56	Yrs.	Months	Days	Hours	Min.	March 2	(1, 1950)	Virgin	ia		
	pu .		Usual Residence of Decedent  10a. State 10b. County		10c Cit	ty, Town or Lo	cation						10d Insid	e City Limits		
	sho	៦	Maryland N/A			timore.								Yes 2 ☐ No		
	28a-1	Director	10e. Street and Number				10f. Zip	Code			10	g. Citizen of What (	Country?	-		
	3a or		2357 Washington	Blvd.			212					U. S. A.	,			
	within 72 hours after death with the Maryland ene. then "natural", or items 23e or 28e-f show he Madical Examiner must be natified at	Funeral	11. Marital Status	12. Was Deceden	t Ever in U	.S. 13.			ispanic Orig	in? (Spec	ify Yes or No- ican, etc.)	14. Race - An		n,		
ထွ	or Its	교	1 ☐ Never Married 2 ☐ Married	Armed Forces 1 ☐ Yes 2 X If Yes, Give			irres, spe 1 ☐ Yes			, Puerto A	ican, etc.)	Black, Wh				
8	ural',	d by	3 Nidowed 4 □ Divorced	Year or Dates	:			- X(40	Specify.			Specify:	White			
7	"nat	Completed	15. Decedent's Ed (Specify only highest gra			16a. Deced		rk done d	during most	of working	9 1	6b. Kind of Busines	ss/Industry			
2	withir ene.	Ë	Elementary/Segondary (0-12)	College (1-4or	r 5+)	Inven		30 1011100	,			Facto	ry			
2	Hygi other	O O	17. Father's Name (First, Middle, Last)						18. Mother	's Name	First, Middle, N	faiden Sumame)				
lan	Aenta Aenta rrked tic ev	To B	Eddie Arnold Ez	zell, Sr.					Sara	h Le	tha Han	ey				
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other then "natural", or items 23a or 28a-f show with injury or other traumatic event, the Medical Examiner must be natified at ance.		19a. Informant's Name/Relationship (7 Shirley Arbogas		or		-				Route Number, Baltimo:	City or Town, State	, <i>Zip</i> Code) 21230			
o,	1 and 1ealit pm 27 ther t		20a. Method of Disposition	i, daugni		Place of Dispo			JOIL DI	.vu	-	Oc. Location - City				
و	Pages nent of h ant: If Ite ury or of		1 Burial 2 □ Cremation 3 □		1 0	emetery, crer Veter	natory or o	other plac	eterv		06-06					
틀	artme ortani Injury		4 □Donation 5 □ Other (Specify 21. Signa □□ → Fune □ Service Licen							, 03-	ne, Inc	Crownsvi	iie, M	ע		
Ba	Depa Impo eny l		I chent	TE	*								MD 0	1007		
			23a. Part1. Enter the disease, or comp	olications that cause	ed the deat							Arbutus, ] st,	Approx	1227 imate Between		
	Physician		shock, or heart failure. List only of Immediate Cause (Final disease or condition	LUN		ance								and Death		
4	/Medical		resulting in death)	a Due to (or a	-								govor.	N-D		
	Examiner		Sequentially list conditions.	b												
	ed sit	lue	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or a	s a consec	uance of):										
	and and II-tran	Examiner	that initiated events resulting in death) Last	c. Due to (or a	s a conseq	uence of);							-			
8760,	icate be executed physician and s the burial-transit	a E			·	•							ř			
9	death certificate be executed e attending physician and of for use as the burial-transit	Physician/Medical		. <b>u.</b>												
Box	eath certific attending p	M/us	230. was decedent pregnant	23c. If yes, outcom			DEctopic p	reanancy				23d. Date of d				
E	e deal	sicle	in the past 12 months? 1 □ Yes 2 ② No	4☐Pregnant a			Other (sp					Month	Day	Year		
<u>о</u> .	res that the de signed by the a be detached f	Phy	9 Unknown		h	uriting in the cu			an in Dawl		22a Did tab	acco use contribute	to the sauce	of death?		
	taw requires that as been signed b 2 should be deta	by	Part II. Other significant conditions of	ontributing to death	but not res	alling in the u	naenying d	ause give	en in Pan I.		238. Did (00.		Probably 4			
Ö	w requir been si should	etec									1					
Rec	o = 0	Completed									24a. Was an autopsy perform	prior t	o completion	ngs available of cause of		
g	iician: Th certificate rector, pag		25. Was case referred to medical	1,1000					OC Diago	of Donth	1 Yes 2 Check only one	DENo 1 □ Yı	es 2□ No			
>	Physician: this certific ral director,	To Be	examiner?	Hospital: 1   Inpat	tient 2	ER/Outpatien	at 3□ DC	OA Othe			e 5 Resider		necity (A. A.)	2010		
פ	g Ph ler th		27. Manner of Death	28a. Date of In	jury	28b. Time of		28c. Injury Work				w injury occurred	7,4 (60	pre Q		
Š	Attending r death. sctor: After oy the fune	atlc	1 Natural 5 Pending 2 Accident investigation		.,,		М		Yes 2□N	lo						
Division of Vital Records,	or Attuiter de Directo	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	288. Place of I	njury - At he etc. <i>(Specif</i>		eet, factor	y, office		28	3f. Location (Str. City or Town,	eet and Number or State)	Rural Route	Number,		
	pital ours a lerel (		29a. Certifier	vsician: To the bes	et of my kno	wiedne death	occurred.	at the tim	o date and	I place, an	d due to the ca	use(s) and manner	as stated			
	To the Hospital or Attending Physician: within 24 hours after death.  To the Funerel Director: After this certific completely filled in by the funeral director.	Medical	(Check only 2 Medical Exert	niner: On the basis and manner s	of examina	ition and/or in	vestigation	, in my of	oinion, death	n occurred	d at the time, da	te and place, and d	ue to the cau	se(s)		
	To th withir To th comp	Me	29b. Signature and title of certifier	λ.			290	c. License	number		29	d. Date signed (Mo	nth, Day, Yea	ar)		
			> Unc	m/V	· co	3	1	リ5	830	3	F	Sruary	28 2	000		
			30. Name and address of person who	completed cause of	AR	n 23a) (Type,	Print)		- RA	511-	no mo	2/204				
			31 Date filed (Month Day Your)	A Dacin	trar's Signa		will	4 01	- //2	-1006		/				
	Sta Registi		31. Date filed (Month, Day, Year) MAR I 4 2005	De Cun	and digital	A STATE OF THE STA	B									

			1 - For State Registrar	State of M	arylan		artmen rtificat					Reg. No.	006	07631
3	Physici	an .	1. Decedent's Name (First, Middle, I			Uan+1	01/				2. Date of De Month	Day	2006 Year	3. Time of Death 10:48 a M
	/Medic	al	Janice  4a. Facility Name (If not institution, g	Marie	)	Hartl		Town, or	r Location of		March	11 4c.	County of Death	10.40 a
1-	Examin	er	3725 Stansbury					enix					timore	
*	Funeral Director		5. Social Security Number 212-34-4936	. Sex 1 □ M 2 ★ 7. Aq	ge (In yrs. 68	last birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bir April 1	12,		place (State or Foreign ntry) aryland
	w w		Usual Residence of Decedent  10a. State 10b. County		10c. Cit	ty, Town or Lo	cation						1.	10d. Inside City Limits
	Maryl	ŗo	Md. Baltin	nore	Pho	penix								1 ☐ Yes 2 XNo
	with the 3e or 28e	Funeral Director	10e. Street and Number 3725 Stansbury	Mill Rd.			10f. Zip	Code	2113	1		10g. Citiz	zen of What Cou	ntry? JSA
9	be filed within 72 hours atter death with the Maryland stal Hyglene. ed other then "natural", or itams 23e or 28e-f show event, the Medical Examinar matter natified at	Funera	11. Marital Status  1 Never Married 2 Married	12. Was Decedent Armed Forces 1 Per 2 X	Ever in U ? No		Was Deced		ispanic Ori an, Mexicar Specify:		ecify Yes or No Rican, etc.)		4. Race - Americ Black, White,	etc.
003	ural',	Completed by	3 ₩Widowed 4 Divorced	If Yes, Give Year or Dates:									Specify: Whi	
15-	"natu	iete	15. Decedent's (Specify only highest)			(Give	dent's Usua kind of wo. DO NOT us	rk done d	during mos	st of worki	ng	16b. Kir	nd of Business/In	dustry
212	e filed within at Hygiene. I other than "	ото	Elementary/Secondary (0-12)	College (1-4or	5+)	Secre			•			В	eth. Ste	eel
land ;	hould be filed id Mental Hygid marked other matic event, il	To Be C	17. Father's Name (First, Middle, La Ray Bryant	st)						ers Name lelin	(First, Middle e Sowa		Sumame)	
Baltimore, Maryland 21215-0036	d 2 s th an 27 is treu		19a. Informant's Name/Relationship Mrs. Karen Tolar		r								Town, State, Zip. Md. 21.	
more	Pages 1 an nent of Heal ent: if item 3 ury or other		20a. Method of Disposition 1 ☐ Burial 2 💆 Cremation 3 4 ☐ Donation 5 ☐ Other (Spe		. 1 4	Place of Dispo cemetery, creating 11 11top	matory or o	ther plac		3-13	-06		wson, Mo	
Balti	permit. Page Department importent; if any injury o		21. Signature of Funeral Service Lic	centee		2:	2. Name an Ruc 1 O F	ck To	owson	Fune	eral Ho	me, I	[nc. 21204	
8760,	Physician and /Medical Examiner build-live site paral-live sit paral-live site paral-live site paral-live site paral-live site	icai Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. REC  Due to (or as  b. Due to (or as  c. Due to (or as	s a consequence	quence of):	<b>υ</b> τ	01	V A-Ve	2 (A	-	740	CER	Onset and Death 4 y 9 Mo
P.O. Box 687	death certifi e attending d for use as	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ♥ No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Feta	aldeath 3	⊒Ectopic pr ⊒ Other (sp		,			2	3d. Date of delive	ery Day Year
	es tha igned be de	Ď	Part II. Other significant conditions	s contributing to death	but not res	sulting in the u	inderlying c	ause giv	en in Part I	l.		tobacco u		he cause of death?
al Records,	The ate ha	Completed									24a. Was auto perfo 1 🗆 Yes		24b. Were auto prior to co death? 1 \( \text{Yes}	opsy findings available impletion of cause of
Vital	Physicien: Th r this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:		1500		Oth	or.		Check only			
οţ	Phys r this sral di	To To	1 ☐ Yes 2 No 27. Manner of Death	28a. Date of Inj (Month, Date		ER/Outpaties 28b. Time o		28c. Injur Wor	4 🗀 INI	ursing Ho	28d. Describe		Other (Special	(7)
ion	Attending Phir death.	ation	1 Natural 5 Pending 2 Accident investigat		ay Year)	Injury	м		k? Yes 2 🗌	No				
Division of	el or Attend s after death si Director: ,	Certification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determine		ijury - At h	ome, farm, st	reet, factory	y, office				(Street and wn, State)		al Route Number,
	To the Hospitel or At within 24 hours after or To the Funerel Directompletely filled in by	ledical (	29a. Certifier Certifying (Check only one)	Physician: To the besi aminer: On the basis and manner s	of examina	owledge, deat ation and/or in	h occurred ivestigation	at the tin	ne, date ar pinion, dea	nd place, ath occurr	and due to the ed at the time,	cause(s) date and	and manner as s place, and due to	stated. the cause(s)
)	To the within To the comple	Me	29b. Signature and title of certifier	oal	M	D		12	e number	74	!	()	signed (Month)	2006
	7 1		30. Name and address of person when the same and address of the same address of the same address of the same and address of the same addre	no completed caused	de th (fter	m 23a) (Type,	Print)	HU	s RC	200	LUTA	HER	VILLE,	MD 2109
	Sta Registr		31. Date filed (Month, Day, Year)	Regist	rar's Sign	ature do	WE STAN							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No: 2. Date of Death 1. Decedent's Name (First, Middle, Last, Month Year **Physician** 11:40 A MARCH 2006 /Medical 4b. City, Town, or Location of Death 4c. County of Death Examiner Mori 9. Birthplace (State or Foreign **Funeral** Months 1 M 2 F Director the Maryland 10c. City, Town or Location 10d, Inside City Limits 10a State 10b. County r 28a-f show 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be fited within 72 hours after death with other than "natural", or iteme 23s or vent, it a Medical Exercises found to 262 Completed by Funeral Was Decedent Ever in U.S. Armed Forces? 1 \_\_Yes \_\_2 ONo If Yes, Give Year or Dates: Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ €o Specify: 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 16b. Kind of Business/Industry dary (0-12) College (1-4or 5+) Name (First, Middle, Last) 18 Mother's Name (First Middle Maiden Be is marked ٥ (Type, Print) Nie 19b. Mailing Address (Street and Number item 27 i 20a. Method of Disposition

Burial 2 Cremation 3 Removal from State Department of H Important: If ite any injury or ot once. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) FAILURE RESPIRATORY DAY Physician /Medical Due to (or as a consequence of): Examiner SEPSI S 11 DAYS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physicien and for use as the burial-transit PNEVMONIA 11 DAY Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>۾</u> 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an this certificate 2 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No Certification: To 1. Inpatient 2 ER/Outpatient 3 DOA After this funeral of 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending investigation L Natural within 24 hours after death.

To the Funarei Director: Afcompletely filled in by the fu 1 Tes 2 No 2 Accident 6 Could not be determined 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physicians To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day, Year)

KAVITA

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



MARCH

MIMORIAL HOSPITAL

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Cecelia Marie Jones March 10 2006 1:50 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Baltimore Towson Gilchrist If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Sex 1☐M 2☐F Days Hours Yrs. 90 May 6 1915 MD 218-36-6693 Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 Yes 2X No Sparks MD Baltimore 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code USA 21152 4 Elizabeth Ct. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: white 3€ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Health Care Private Nurse 6 n/a 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Helen Manor Leonard John Bandell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4 Elizabeth Ct., Sparks, MD 21152 Helene Shugart/daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 3/13/06 Baltimore, MD Baltimore Cemetery 21. Signature of Emperational Licensee 22. Name and Address of Facility Lemmon Funeral Home of Dulaney Valley, Lowell M. Lemmon 10 W. Padonia Rd., Timonium, MD 21093 20a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Se DSIS DAYS disease or condition resulting in death) Due to (or as a cons ischemic vicer e c Sequentially list conditions, lany, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown FVActore 24a. Was an autopsy performs 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No Left 1 ☐ Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Vither (Specify) 1 Yes 2 No 28c. Injury at Work? 28d. Describe how injury occurred Patient As Ambulating with watter to Gat room. 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Injury 1 Natural 5 Pending 10:45 AM 1 ☐ Yes 2 No 2 Accident 3 Suicide December 29, 2005 investigation Hooked Foot on edge and Fell 6 ☐ Could not be determined

certificate be executed 68760, Vital After death.

Examiner Physician/Medical þ Completed Be Certification: To

Medical

**Physician** 

/Medical

Examiner

Director

by Funeral

Completed

Be

**Funeral** 

Director

28a-f show

nii. Pages 1 end 2 should be filed within 72 hours after deeth with the Maryla ariment of Heelth and Mental Hyglene. orient: if item 23s or 28a-f ahou orient: if item 27s enarked other than "natural", or items 23s or 28a-f ahou injury or other traumatic event, it is Madical Examinate must be notified as

Departi Departi Important any int

**Physician** 

Examiner

/Medical

Maryland 21215-0036

Baltimore,

4 Homicide

29a. Certifier

or Attending neral Director: A within 24 hours e To the Funeral I Pours 6

ELL

Frature

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Daughter's Home

no

28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Flizabeth COUST Spries/Gleacoe, Md 21152 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier

5205

29d. Date signed (Month, Day, Year) MI Arch 10, 2006

30. Name and address of person who co inpleted cause of death (Item 23a) (Type, Print) last, Balto, md 21204 6701 5BINE 31. Date filed (Month, Day, Year)

State Registrar

			1 - For State Registrar	State of Ma	arylan	-	artment of rtificate of		Mental Hy	giene Rag. No.	06	07634	
	Physicia	an	1. Decedent's Name (First, Middle, La	*					2. Date of De Month	ath Day	Year	3. Time of Death	
	/Medic		Mary Thelma John						March	10	2006	1:45 A <sup>M</sup>	
	Examin	er	4a. Facility Name (If not institution, gi					or Location of Dea	atn	Tall	nty of Death		
H	Funeral		William Hill Mano 5. Social Security Number 6.		je (In yrs.	last birthday)	Easton If Under 1 Yea	r If Under 24 Hr				lace (State or Foreign	-
	Director		220-07-2732	1□M 2ਊF	9	3 Yrs.	Months Days	Hours Mir	n. (Month, Da 12–24–	y, Year) 1912	MD	ntry)	
	pu »		Usual Residence of Decedent  10a. State 10b. County		100 Cit	y, Town or La	eation		<u> </u>			0d. Inside City Limits	_
	faryla s show	ō	m 11 .			lghman	Cation				Ι,	1 ☐ Yes 22€No	
	28a-	Director	MD Talbot  10e. Street and Number		11.	rgiillaii	10f. Zip Code			10g. Citizen	of What Cour	ntry?	-
	h with	i Di	21630 Chicken Po	int Rd.			2167	1		USA	A		
	ems Ser mu	Funerai	11. Marital Status	12. Was Decedent Armed Forces?		.S. 13.			(Specify Yes or No erto Rican, etc.)	- 14. F	Race - Americ Black, White,		-
ဝ	or it	by Fu	1 Never Married 2 Married  3XXVidowed 4 Divorced	1 ☐ Yes 2 🛣 If Yes, Give		1	1 ☐ Yes 2 ☐xNo		,		cify: Wh	_	
2-003o	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other then "natural", or items 23a or 28a-f show aumatic event, the Medical Evantisating the rollified at		15. Decedent's 8	Year or Dates:		16a. Dece	dent's Usual Occi	upation		16b. Kind o	f Business/In		-
C 12	nin 72 in "ne Medic	piet	(Specify only highest g. Elementary/Secondary (0-12)	rade completed)  College (1-4or	5.4\	(Give	kind of work don DO NOT use retir	e during most of w	vorking	700. 1010		addity	
7	giene giene er the	Completed	12	College (1-40)	J+)	Hor	nemaker			Ow	n Home	2	
yland	be file tal Hy d oth	Be (	17. Father's Name (First, Middle, Las	t)				18. Mother's N	ame (First, Middle	, Maiden Sun	name)		
<u> </u>	Men Men narke natic	5	Thomas Pumphre						eona Woli			0.11	4
Mar	d 2 st th and 7 is n traun		19a. Informant's Name/Relationship						Rural Route Numb iel, MD 2		wn, State, Zip	(Code)	i
<u>a</u>	permit. Pages 1 and 2 should be Department of Health and Mental Importent: If item 27 is marked any injury or other traumatic as <u>once.</u>		Oliver Stinchcon 20a. Method of Disposition	ib/Nepnew	20b. F	Place of Dispo	sition (Name of	3.5	Date Date		on - City or To	own, State	-
Ē	Pages ent of nt: If i		1 ☐ Burial 2 ☐ Cremation 3		G1°	en Hav	matory or other pi en Memor	ial Mar	ch 18, 2006	Glen Bu	ırnie.	MD	
saitimore,	partm porte y inju		21. Sign the of Funeral Service Lice	ensee		Par	K. 2. Name and Add		2000	1 5	econd	Ave. SW	
ם —	8258		Low		MO 1	1411 S	ingleton	Funeral	Home, P	.A. G16	en Bur	nie, MD 210	6
	Pnysician /Medical Examiner		23a. Part1. Enter the disease, or conshock, or heart failure. List only immediate Cause (Final disease or condition resulting in death)	Vione cause on each I	ina		ler the mode of di lon ar M	-	iac or respiratory a	rrest,	C	Approximate Interval Between gnset and Death	-
9/00,	be executed ician and burial-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as  c. Due to (or as  d.	s a conseq	uence or):	arri	(r) (r) s			/		
O. Box o	ath certif attending for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Feta	Ideath 3	□Ectopic pregnan □ Other (specify)	су			Date of delive Month	ery Day Year	
cords, r	w requires that the de been signed by the s should be detached	by	Part II. Other significant conditions	contributing to death to	but not res	sulting in the u	inderlying cause of	given in Part I.		tobacco use c Yes 2 No		he cause of death? pably 4 \(\sum \)Unknown	
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T.		Com					disen	2		ormed?	death?	2 No	
Vital	Physicien: The law this certificate has I ral director, page 2 s	Be	25. Was case referred to medical examiner?	Manital					eath (Check only				
10	hy this ald	- To	1 Yes 2 No			ER/Outpatier			Home 5 Res			(y)	-
	ng ftei	tion	1 Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	ay Year)	Injury	W	ork? □Yes 2□No	200. Describe	now injury oc	curred		
DIVISION	Hospitel or Attending 24 hours after death. Funerel Director: After tely filled in by the fune	Certification:	2 Accident investigati 3 Suicide 6 Could not 4 Homicide determine	be an au	ijury - At h tc. <i>(Specii</i>	ome, farm, st fy)	reet, factory, offic			Street and Nu wn, State)	umber or Rura	al Route Number,	-
	To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu	Medicai C	29a. Certifier 1 Cartifying F (Check only 2 Medical Ex-	Physician: To the best aminer: On the basis of and manner s	of examina	owledge, deat ation and/or in	th occurred at the	time, date and pla opinion, death of	ace, and due to the courred at the time,	cause(s) and date and place	l manner as s ce, and due to	stated. the cause(s)	-
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	10 1		30. Name and addres of person wh										
	1		Robert Sanchez  31. Date filed (Month, Day, Year)	, M.D.			ans Lane	, Easton	, MD_2160	)1			
	Sta Registi			06	1 1	Soc	de)						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend item 16b per fh 9853 3-21-06 vt

State of Maryland? Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Physician 12:36 A. M 2066 0 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner N/A **Baltimore** Bon Secours Hospital If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Jul 2, 1922 Birthplace (State or Foreign Country)
 Virginia 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ **X**/4 2 □ F 227-16-3679 Yrs. 83 Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits rthan "naturel", or items 23s or 28s-f show the Medical Examiner must be notified at 1 ☐Yes 2 ☐ No Baltimore N/A Director Maryland 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 1934 Mosher Street 21217 U.S.A Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene.
ant: If item 27 is marked other than "naturel", or item ury or other treumetic event, the Medical Examinar 1 □XYes 2 □ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ XViarned Baltimore, Maryland 21215-0036 1943 1 ☐ Yes 2 ☐ XNo Specify: Specify: Black Completed by 3 Widowed 4 Divorced 1946 16b. Kind of Business/Industry
Abex Corp 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) -APEX Company Elementary/Secondary (0-12) College (1-4or 5+) Skilled Worker 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mary Fitzgerald Richard L. Jones Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1934 Mosher Street Baltimore, Maryland 21217 Gladys P. Jones Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 □ Maurial 2 □ Cremation 3 □ Removal from State Depertment of Important: if any injury or once. 03/15/06 Owings Mills, Md. Garrison Forest Veterans Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Arvice Livin 22. Name and Address of Facility Estep Brothers Funeral Service, P. A. 1300 Eutaw Place Baltimore, Md 21217 death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death 23a. Part I. Enter the disease, or complications that caused th shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** 1C4TE CARDIG PULYONARY ARREST /Medical Due to (or as a consequence of): Examiner CARDIOVASCULAR THEROSCLEROTIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physicien and for use as the burial-transit Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☒ No 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 3 Ectopic pregnancy Month Year Day 4 Pregnant at time of death 5 Other (specify) P.O. 1 been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by MELLITUS 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No CEREBROVASCULAR ACCIDENT 2□ No 1 ☐ Yes 2X No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Anpatient 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification; To 2 ☐ ER/Outpatient 3□ DOA this : After thi 27. Manner of Peath
Natural
2 Accident 28b. Time of 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28c. Injury at Work? 5 ☐ Pending investigation 1 Yes 2 No death. within 24 hours after death To the Funerel Director: completely filled in by the 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide 1x Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) There of tome to 10, Staff physician DOE 291 0.30. Name and address of person who completed cause of death (Item 23a) (Type, Print) FRANK A HAMILTON, M.D. 03-09-2006

Registrar

DHMH 17 Rev 1/2001

State

Street, BALTIMORE, MD, 21223

BON SECURS HOSPITAL 2000 W. BALTIMORE

MAR 1 4 2006

32. Régistrar's Signature

31. Date filed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 2006 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death Examiner Sykesuille

Il Under 1 Year | f Under 24 Hrs. | 8. Date of arrow Birthplace (State or Foreign Country) rs. last birthday) **Funeral** Days 1□M 257F Yrs. 90 Director Aug 19, 1915 Maryland 216-28-8874 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Importent: if item 27 is marked other than "natural", or Items 23e or 28e-f show eny injury or other treumatic event, the Medical Examples. 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County 1 ☐ Yes 2√ No MD Sykesville Director Carroll 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 710 Obrecht Road 21784 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No II Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify: white 3 ☐ Widowed 4 ☑ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry unk (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 0 store buyer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John Vincent Murphy Nellie Jones 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Nell Singleton/daughter 8107 Graystone Lane Pasadena, MD 21122 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State \* 4 ☑ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee
Renald S. Wade 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate ause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to for as a consciouentel of use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 the attending physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown à 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed 2 □ No 1 🗆 Yes 2 1 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Vursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA Certification; To this 27. Mann of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred **Director:** After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours a To the Funerel C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Hord J. Men. MO rs.nes Conta Do Reistantion Al 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rob -- 1 L. Moss, MD 114 2. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** KORMAN WALLACE MARCH 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CARROLL CARROLL HOSPITAL CENTER WESTMINSTER If Under 1 Year tf Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 1**√**M 2□F 214-26-3125 Director 9/14/1930 MARYLAND Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State d other than "natural", or Items 23a or 28a-f shovevent, the Medical Examinating to notified at 1 ☐ Yes 2 🔀 No Director FINKSBURG CARROLL 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 128 LASSITER CIRCLE 21048 USA 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after Hygiene. 1 XYes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: WHITE ģ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuat Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) CONSTRUCTION PAINTER 9 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be fill ment of Health and Mental H tent: If Item 27 is marked off jury or other traumatic even KORMAN FRED MAY BROTHERS 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) KATHRYN M. KORMAN - WIFE 128 LASSITER CIRCLE, FINKSBURG, MD 21048 20b. Place of Disposition (Name of cemetery, crematory or other place) 3/13/06 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 □ Donation 5 € Other (Specify) ENTOMBMENT EVERGREEN MEM.GARDENS FINKSBURG, 22. Name and Address of Facility FLETCHER FUNERAL HOME 21. Signature of Funeral Service Licensee 254 E. MAIN ST., WESTMINSTER, MD. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each time. Approximate Interval Between Onset and Death tmmediate Cause (Final disease or condition resulting in death) Boul Physician /Medical Due to (or as a consequence of): Examiner Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner anding physicien and use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) ed by the e Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 2 Unknown Infarchion certificate has been si rector, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 2 No 1 🗌 Yes 250 No 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28c. Injury at Work? Certification; 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after deal To the Funeral Director. 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide (Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 3/10/2006 H53939 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21157 Imanoel. Do; 218 washing ton Hts Med. Ctr; Westminster, 31. Date filed (Month, Day, Year) 2. Registrar's Signature MAR 1 4 2006 Registrar

			State of Maryland / Department of Heal  1- State Registrar Certificate of Department			2006	0761.0
			1. Decedent's Name (First, Middle, Last)		Reg	g. No U U U	3. Time of Death
П	Physicia		William Henry Ludwig		Month 3	Day Year V. ZCOC	200 Am
	/Medic Examin		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Local	ation of Death		4c. County of Death	
	LXamin	-	Baltimore Washington Med Ctr Glen Burn	nie		Anne Ar	undel
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If U	Under 24 Hrs. 8	Date of Birth	9. Birth	place (State or Foreign
	Director	Į	215-30-9317 73 Yrs.	0	Date of Birth (Month, Day, 19/26/1	932	MD
	put		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
	ahor sho	ō	MD Anne Arundel Pasadena				1 ☐ Yes 2 🔀 No
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	with the or	ਰ	8438 Arbutus Road 21122		101	U.S.A.	inu y :
	leath	era	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispan	nic Origin? (Speci	fy Yes or No-	14. Race - Ameri	can Indian,
36	should be filed within 72 hours after death with the Maryland of Mental Hygiene. marked other than "natural", or items 23a or 28a-f show imatic event, the Medical Examiner must be notified at	by Funeral I	1 Never Married 2 Married 1 Mayes 2 No 1951	flexican, Puerto Ri pecify:	can, etc.)	Black, White,	etc. hite
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Maryland	2 sho		19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and N				·
	ges 1 and 2 shouid t of Health and Men if item 27 is marke or other traumatic		Marlene Ludwig / Wife 8438 Arbutus  20a. Method of Disposition (Name of	Road,	-	ena, MD 2 Oc. Location - City or To	
5	Pages 'nent of H		1 ■ Burial 2 □ Cremation 3 □ Removal from State cemetery, crematory or other place)				
Baltimore,	t. Pag rtment rtant: i		4 □ Donation 5 □ Other (Specify) Cedar Hill Cem  21. Signature of □ leral Service Licensee 22. Name and Address of			Baltimore	
Ba	permit. Pag Department Important: i any niury o		169 Riviera				Home, PA 21122
			25a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, surshock, or heart failure. List only one cause on each line.				Approximate Interval Between
8760,	Physician / Medical Examiner  b physicien and physicien are the parial-transit	dical Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  a. Curve Arthy the Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):		avione		Onset and Death Windle 5
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Division of Vital Records,	The law require tte has been sig page 2 should b	Completed			24a. Was an autopsy performe	prior to co	opsy findings available impletion of cause of
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<u></u>	Physician: r this certific ral director,	2	1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA Other: 4	4 Nursing Home	5 Residen	ce 6 □Other (Specia	5⁄)
ion o	To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate his completely filled in by the funeral director, page	atlon;	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation  28a. Date of fnjury (Month, Day Year)  28b. Time of Injury 28c. Injury at Work? 1 Yes		d. Describe how	v injury occurred	
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	To the within To the Comp	Me	29b. Signature and title of certifier 29c. License nun		290	d. Date signed (Month,	Day, Year)
)	, 1		I Renert Double WWD 1396	e60	i u	Neuron II,	2006
	25		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Robert C-Dout to, WD. 900 E. Fort A				21230
	Sta Registr		31. Date filed (Month, Day, Year)  MAR 1 4 2006  32. Registrar's Signature	1 46 1 1 100			
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			For State Registrer	State of M	aryland		irtmen tificate			and M		giene Reg. No:	06	07641
	Physici	an	1. Decedent's Name (First, Middle,								2. Date of Dea Month	Day	Year	
	/Medic	al	Dorothy C. La				4b. City.	Town, or	Location o	of Death	1711-11		200 inty of Dea	
	Examin	er	Saint Josep			er				DWSC	n			timore
	Funeral Director		215-28-9625	5. Sex 7. Ag 1 ☐ M 2 ☆ F	e (In yrs. Ia: 77	st birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Birtl (Month, Day Sept 4,	/. Year)	C	rthplace (State or Foreign ountry) ryland
	land DW		Usual Residence of Decedent  10a. State  10b. County		10c. City,	Town or Lo	cation							10d. Inside City Limits
	Mary F-f sh	tor	MD Balt	imore		Timon	ium							1 □Yes 2√□No
	or 28	Director	10e. Street and Number				10f. Zip	Code	016			10g. Citizen		country?
	eath w		2300 Dulaney Va	12. Was Decedent	Ever in U.S.	13. \	Was Dece	tent of Hi	210		ecify Yes or No-		USA Race - Am	erican Indian,
36	filed within 72 hours after death with the Maryland Hygiene. other than "natural", or Items 23a or 28a-f show ent, the Maulcal Examiner must be mailfied a	by Funerai	1 Never Married 2 Marrie 3 Widowed 4 Divorced	Armed Forces?	)		fYes, spec 1 ☐ Yes		Specify:	, Puèrto	ecify Yes or No- Rican, etc.)		Black, Whi ec <i>ify:</i> W	ite, etc.
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lary	2 should have and have many many many many many many many many		19a. Informant's Name/Relationsh	ip (Type, Print)		19b. Mailir	ng Address	(Street a	ind Numbe	er or Rura	al Route Numbe	r, City or To	wn, State,	Zip Code)
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or items 23a or 28a-f show any figury or other traumatic event, the Marical Examiner must be multified at ance.		James J. Lacy,  20a. Method of Disposition  1 □ Burial 2 □ Cremation	_	COL	5004 ace of Dispo metery, cren	sition (Nar	ne of		ad#	2612 ba	1time1 20c. Location	on - City o	D 21210 r Town, State
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	Physician		23a. Part 1. Enter the disease, or of shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)	complications that cause only one cause on each	ine.	. Do not ent	er the mod	le of dying	g, such as	cardiac o	or respiratory ar	rest,		Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in coatry	Due to (or as		ence of):								
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on	Attending in death.  ector: After by the fune	ation	1 Natural 5 ☐ Pending 2 ☐ Accident investig	(Month, D.	ay Year)	Injury	М		k? Yes 2□					
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	To th within To th comp	Me	29b. Signature and title of certifier				29	c. Licens	e number			- /	1-1	nth, Day, Year)
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			30. Name and address of person	who completed cause of	death (Item	23a) (Type,		o principal de antico		200 BOK K - 2.0	75 to 1 475	a		
	St	ate	31. Date filed (Month, Day, Year)	732. Regis	trar's Signat	ure A	<del>VIII. I</del>	انتالهالية	TA TAF	HIX Y L	_AND_2	1204		
	Regist	rar	MAR 1 4 200	36	A.	A PROPERTY OF								

#### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 2006 Lauren 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street end humber) Harford Bel Air Lorien-Bel Air | H Under 1 Year | H Under 24 Hrs. | 8. Date of Birth (Month, Day, Yeer) | 9. Birthplace (State or Foreign (Month, Day, Yeer) | 9. Birthplace (State or Foreign (Month, Day, Yeer) | 9. Pennsylvania 7. Age (In yrs. last birthday) 5. Social Security Number 1 XM 2□ F Yrs. 86 196-09-4364 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 1 ☐ Yes 2 No Bel Air Maryland Harford 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21015 1909 Emmorton Road Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 1 XYes 2 No If Yes, Give WWII 1 ☐ Never Married 2 Married 1 ☐ Yes 2 XNo Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elementary/Secondary (0-12) College (1-4or 5+) Industrial Manufacturer Manager 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Lafey Robinson L.A. Lydic 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1441 Moonshadow Rd., Bel Air, MD 21015 Lauren A. Lydic, Jr./Son 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Grandview Cemetery 3-13-06 Southmont Borough, PA 22. Name and Address of Facility McComas Funeral Home, P.A. 21. Signature of Funeral Service Licensee Martet-1317 Cokesbury Rd., Abingdon, MD 21009 131/ CORESDUTY Rd., ADITIQUOI of completions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. 23a. Part1. Enter the disees shock, or heart failure. Immediate Cause (Final disease or condition resulting in death) CONGESTIVE HEART PAICURE ENDSTAGE Due to (or as a consequence of) Due to (or as a consequence of) Due to (or as a consequence of) 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2**/** No 1 □ Yes 2 □ No

**Physician** /Medical Examiner

Physician

/Medical

Examiner

10a. State

**Funeral Directo** 

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Completed

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, it is Medical Examiner must be notified at

Baltimore, Maryland 21215-0020

by Physician/Medical Examiner physician and s the bunal-transit Completed Be Certification: To To the Hospital or Attanding Physi within 24 hours after death.

To the Funeral Director: After this c completaly filled in by the funeral dir

29a. Certifier

Medicai

or Attanding Physician: The law requires that tha death certificate ba axeculed after death.

Division of Vital Records, P.O. Box 68760,

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CARDIOMYOPATHY, MYELODYSPLASTIC SYNDROME ATRIAL FIBRILLATION DIABETES MELLITUS 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 No 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Dey Year) 28b. Time of 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 4 Homicide

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Yeer) 29b. Signature and title of certifier D45344 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 622 SOUTH UNION AVE HAVREDE GRACE, MUZIOTS SURESH DHANJANI 32. Registrar's Signature 31. Date filed (Month, Dey, Yeer)

State Registrar

DHMH 17 Rev 1/2001

State Registrar

			For State Registrar	State o	f Marylan		artment rtificate					giene Reg. No. 006	07644
	Physicia		1. Decedent's Name (First, Middle, Elizabeth	Last)	Larkin						2. Date of Dea March 1	10, Day 2006 Year	3. Time of Death 3:21 a M
	/Medic Examin		4a. Facility Name (If not institution, 8820 Walther	-			Р	arkv	Location o			4c. County of Death	9
Ou a	Funeral Director		212-07-4513	6. Sex 1 ☐ M 2 ☐ F	7. Age (In yrs. I	, .	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Birth Month, Day	9. Birth 24, 1912 Mai	nplace (State or Foreign untry) CYLand
	ehow	2	Usual Residence of Decedent  10a. State 10b. County  MD Bal:	timore	10c. City	, Town or Lo	cation kvill						10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	r 28a-f	Irecto	10e. Street and Number	crmore		Lat	10f. Zip					10g. Citizen of What Co	
	ath witi	ralD	B820 Walther					2123				U.S.A.	
36	be filed within 72 hours after death with the Maryland Hygiene. All Hygiene. do ther than "natural", or tema 23a or 28a-f ehow do ther than "natural", or tema 23a or 28a-f ehow event, the Madical Examerar must be notified at	by Funeral Director	11. Marital Status  1 ☐ Never Married 2 ☐ Marrie 3 ☑ Widowed 4 ☐ Divorced	Armed F	2 No ve No		Was Deced If Yes, spec		spanic Ori n, Mexican Specify:	gin? (Spe 1, Puerto	ecify Yes or No- Rican, etc.)		
Maryland 21215-0036	ithin 72 hours is. isn "naturs Madical E	Completed	15. Decedent (Specify only highes Elementary/Secondary (0-12)			(Give life.	dent's Usua kind of wor DO NOT us	k done d e retired,	ition u <i>ring m</i> os	t of worki	ng	16b. Kind of Business/	
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Mar	nd 2 sh alth and 27 le rr or traum		19a. Informant's Name/Relationsh Frank Lidinsky		,		3				20, Tows	or, City or Town, State, 2	
lore,	iges 1 a nt of Hei if item or othe		20a. Method of Disposition 1 XBurial 2 ☐ Cremation			lace of Dispo					5/06	20c. Location - City or	
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic evonce.		4 ☐ Donation 5 ☐ Other (Sp. 21. Signature of Funeral Service L			reland Dau 22	2. Name an	d Addres	s of Facilit	y Ruc	k Towsc	n Funeral H	
	2D 2 6 0		23a. Part1. Enter the disease, or	complications that	caused the deat						or respiratory ar	21 204 rest,	Approximate Interval Between
	Physician /Medical		shock, or heart failure. List of the shock, or heart failure. List of the shock of	Chr	onic 0	bstr	ncti	ve 1	Ruh	nova	my Do	isease	Onset and Death
(4)	Examiner			Due to	(or as a conseq	uence of):					V		
	nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to	(or as a conseq	uence of):							
,097	ate be executed hysician and the burial-transit		that initiated events resulting in death) Last	C. Due to	(or as a conseq	uence of):							
6876	tificate t ng physic as the b	edica		d									
.O. Box	The law requires that the death certificate be executed te has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	1 Live	itcome of pregna birth 2 Feta nant at time of d nown	death 3	⊒Ectopic pr ⊒ Other (sp					23d. Date of deli Month	ivery Day Year
rds, P.	w requires that I been signed by should be deta	þ	Part II. Other significant condition	ns contributing to c	leath but not res	ulting in the u	inderlying c	ause give	on in Part I			obacco use contribute to	
l Records,		Completed									24a. Was autop perfor 1 Yes	osy prior to death?	ntopsy findings available completion of cause of 2 No
Vita	iclan: certific rector,	Be	25. Was case referred to medical examiner?	Hospital:				Othe			(Check only o		
u of	D - 40	on: To	1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending	28a. Date ( <i>Mor</i>		28b. Time of Injury	of 2	8c. Injury Work	at			dence 6 Other (Spectors)	cify)
Division of Vital		Certification;	2 Accident investig 3 Suicide 6 Could r 4 Homicide determine	ot be 28e. Plac	e of Injury - At ho ling, etc. (Specif		M reet, factory		Yes 2□	No	28f. Location (S City or Tow	Street and Number or Ru vn, State)	ural Route Number,
	To the Hospital or within 24 hours after To the Funeral Director completely filled in	edical Ce	29a. Certifier 1 Certifyin (Check only one)	Examiner: On the I	pasis of examina	wledge, deat	th occurred ivestigation	at the tim	ie, date ar pinion, dea	nd place, ath occur	and due to the c	cause(s) and manner as date and place, and due	s stated. to the cause(s)
	To the within 2 To the comple	Mec	29b. Signature and title of certifier	2 M	ner stated.		1	License	(/ 8	37		29d. Date signed (Monta	h, Dey, Year)
/	OV		30. Name and ddress of person	who dompleted be	of de th (Iten	Туре	Print)	Ue	N	D	212	34 JUAN	FALAR AGA
	Sta	ate rar	31. Date filed (Month, Day, Year) MAR 1 4	2006	Registrar's Signa	ture	sall I		(		0 . 0		

			For State Registrar	State of Marylar		artmen			nd Men		iene	16	07645
	<b>D</b>		1. Decedent's Name (First, Middle, Last	")	<u> </u>					ate of Dear	th Day	Year	3. Time of Death
	Physicia /Medic	144	Mary Rose	Lambros						onth 03		2006	2240
1	Examin		4a. Facility Name (If not institution, give	street and number)	ر سا	4b. City,	Town, or Lo	ocation of I	Death		4c. County		
			Peninsula hegional	medical Ce	ner	50	Jush	ury			1000	micc	
	Funeral		5. Social Security Number 0 6. Se	7.4 c/M =		If Under Months		f Under 24 Hours	Min. //	ate of Birth Month, Day	Year)	9. Birthp	lace (State or Foreign try)
	Director		220-46-4602	8	36 Yrs.				Mar	ch 1,	1920	Mar	yland
	land	Ì	10a. State 10b. County	10c. C	ty, Town or L	ocation						1	0d. Inside City Limits
	Mary	ò	Md. Harfo	and		Bel	Air						1 ☐ Yes 2 🖔 No
	28a	Director	10e. Street and Number	or u		10f. Zip		-		1	0g. Citizen of	What Coun	itry?
	3a or		216 Victory Lar	ne			210	14			1	USA	
	death ms 2	by Funeral	11. Marital Status	12. Was Decedent Ever in U	J.S. 13.	Was Deced	lent of Hisp	anic Origin	n? (Specify	Yes or No-		e - Ameno	
9	after or its	2	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 🛣 No If Yes, Give		1 Yes, spec		мөхісап, і Specify:	Pueno Ricar	1, Otc.)		ck, White,	
21215-0036	be filed within 72 hours after death with the Maryland Hygiene. A dither then "natural", or items 23a or 28a-f show do other then "natural" or items 23a or 28a-f show event, it a Modical Examinar must be notified at		3 Widowed 4 Divorced	Year or Dates:		10165	ZAJNYO ,	эрөспу.			Specif	y: W	hite
2	72 h	Completed	15. Decedent's Edu (Specify only highest grad	ucation de completed)	(Give	edent's Usua e kind of wor	rk done dur	on ing most o	of working		16b. Kind of B	usiness/Ind	dustry
2	dithin	d d	Elementary/Secondary (0-12)	College (1-4or 5+)		DO NOT us		10.010				+ /D	W.,
N.	filed v Hygie other t	ပိ	12 17. Father's Name (First, Middle, Last)			Busine			Name /Fin	-	lestaur Maiden Suman		ar.
i i		Be					"	B. MOUTION S				•	
⋛	should be nd Menta marked matic ev	ဥ	Peter F 19a. Informant's Name/Relationship (T)		10h Mail	in n A dd	/Strant and	d Alumbo c			ramaro		Code
Maryland	d 2 sho		Mrs. Penny Eberts/[			Victor					; City or Town, yland :		C086)
o,	s 1 and 2 should if Heelth and Mer item 27 ie marke other traumatic	ŀ	20a. Method of Disposition	20b.	Place of Disp	osition (Nan	ne of		Date		20c. Location		wn. State
Baltimore,	Pages net: If it int: or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ F	Removal from State	cemetery, cre	matory or o	ther place)			110			
₽	permit. Pages Department of importent: If i eny injury or o		4 Donation 5 Other (Specify)		ek Ort				/15/06		loodlaw		
Ba	Depa impo eny i		21. Signature of Funeral Service Licens	10 11		1050 Y							ome, Inc.
			23a. Part1. Enter the disease, or comp	lications that caused the dea							ryland	2120	4 Approximate
			shock, or heart failure. List only o Immediate Cause (Final	ne cause on each line.						pilatory arr	001,		Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)		LAR +	ALLIY	MM	IA					
	Examiner			Due to (or as a consec	PBRU	1000	1						
	*	is is	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a consec		LITTIO	1 4						
	nst lsn	를	Cause (Disease or injury	HYDYD	TENSI	OIN							
	be executed icien and burial-translt	Examiner	that initiated events resulting in death) Last	Due to (or as a consec	-				-				
760	ate be executed hysicien and the burial-transit	call		d									
	ificat g phy as the			U									
Вох	death certifica e attending ph id for use as th	Z	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Fet		∏Estenia sa					23d. Da	te of delive	ry
m .	deatl e atte	Cla	in the past 12 pronths?	4☐Pregnant at time of o		□Ectopic pr □ Other (sp					Mo	onth	Day Year
O.	at the de by the a	Physiclan/Med	9 Unknown	9□ Unknown									
'n.	The law requires that the ate has been signed by th page 2 should be detache	by P	Part II. Other significant conditions co	ntributing to death but not re-	sulting in the	underlying c	ause given	in Part I.	:	23e. Did tol	pacco use cont	tribute to th	e cause of death?
Ë	w require been sig								_	1 🗆 Ye	s 2000	3 🗌 Prob	ably 4 □Unknown
ပ္က	awre is be 2 sho	per							:	24a. Was a	n 24b.	Were auto	osy findings available impletion of cause of
Vital Records,	: The law cate has t	Completed								autops perform Yes ∷	med2	death?	
ia	ilcian: Th certificate rector, pag	Bec	25. Was case referred to medical examiner?				, 2	6. Place o	f Death (Ch				
<u> </u>	ysic nis ce	P	1 Yes 2 No	Hospital: 1 🔲 Inpatient 2 🗆	] ER/Outpatie	ent 3 V DO	Other:	4 🗌 Nursi	ing Home	5 🗌 Reside	ence 6 🗆 Oth	ner (Specify	·)
Division of	Attending Physician: I death. Sector: After this certification the funeral director.		27. Manner of Death  Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of	of 2	8c. Injury at Work?	t	28d.	Describe ho	w injury occur	red	
<u> </u>	endii sath. br: A	atie	2 ☐ Accident investigation			М	1 🗌 Ye	s 2 □ No	0				
<u>≅</u>	i or Attend after death Director: ,	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Speci	iome, farm, si	treet, factory	r, office		28f. L	ocation (St	reet and Numb n, State)	er or Rura	l Route Number,
	To the Hospitel or At within 24 hours after or To the Funeral Direct completely filled in by			1									
	Hosp 14 hou Fune ely fil	edlcal	(Check only 2 Medical Exam	rsician: To the best of my kniner: On the basis of examination	owledge, dea ation and/or i	th occurred nvestigation,	at the time, in my opin	date and piion, death	place, and o occurred at	ue to the cathe the time, d	ause(s) and ma ate and place,	anner as st and due to	ated. the cause(s)
	To the within 2. To the Complete	Med	one) 29b. Signature and title of certifier	and manner stated.			. License n				9d. Date signe		
	F \$ P S		March 1	i37 .			_	_		-	21,01	1	ung, real/
7	9		10001001	~()			763	422			2/12/	6	
1	5 1		30. Name and address of person who c	ompleted cause of death (Ite	m 23a) (Type	, Print)	72 02	) I O-	CAM I	en Air	y MD	nich	7,
9			31. Date filed (Month, Day, Year)	32. Registrar's Sign	ature	2 all	1236	14.12)	BALL	MACIE	4 154)	400	4
	Sta Registr			2006	Sh A	Scarle.							

CPM06-01678 Unpend item#23a,PIF.27,28a-F,perWe,g853, 3/18/06 IT.
State of Maryland / Department of Health and Mental Hygiene Catherine Lewis 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death March **Physician** 08, 2006 Catherine Ann Lewis 07:15 AM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Brooklyn Anne Arundel 279 Rupert Circle If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Y Oct. 10, 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) . 1964 **Funeral** 1 ☐ M 2 🗓 F 212 92 0063 41 Yrs. Oct. Maryland Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f ehor other traumatic svent, the McCical Examinar must be notified at 1 ☐ Yes 2x No Maryland Baltimore Anne Arundel Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S. 279 Rupert Circle 21225 death \ Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ঐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after Hygiene. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2X No Specify: <u>ک</u> 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 9th permit. Peges 1 and 2 should be file Department of Health and Mental Hy important: If Item 27 is marked othn any injury or other traumatic svent, 0008. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Helen (unknown) Merle Crampton Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John Lewis Sr./ Husband 279 Rupert Circle Baltimore, Maryland 21225 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ACremation 3 Removal from State 3/10/2006 Baltimore, Maryland Bayview Crematory 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Gonce Funeral Service, P.A. ano 4001 Ritchie Highway Baltimore, Maryland 21225 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Oxycodone intoxication resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examiner if any leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): The law requires that the death certificate be executed use as the burial-transi the attending physicien and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy jo in the past 12 months? Month Day 5 Other (specify) Yes 2 No detached 9 Unknown 9 WUnknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š P hypertensive atherosclerotic cardiovascular disease 1 Yes 2 No 3 Probably 4 XUnknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? has page 2 autopsy performed? certificate 1 ¥Yes 2□ No 1 XYes 2 🗆 No or Attending Physician: 25. Was case referred to medical examiner?
1 ∑ Yes 2 □ No Be 26. Place of Death | Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) SCENE ဥ ë this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 Pending investigation 1 Natural Fnd 7:15 AM 1 ☐ Yes 2X☐ No unk Fnd 3/8/2006 death 2 Accident completely filled in by the Director 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 279 Rupert Circle 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide Brooklyn, found at home within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical = 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier March 09, 2006 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rollak will Penn Street, Baltimore, Maryland 21201

State Registrar 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

32. Registrar's Signature

			_ 101	eartment of Health and Mer ertificate of Death	ntal Hygiene Reg. No. 006 07647
	Physicia /Medic		1. Decedent's Name (First, Middle, Last) Virginia Lehman		Date of Death Month Day Year  AARCH G 2006  A M M M M M M M M M M M M M M M M M M
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death  Carrol1
	Funeral	G,	Copper Ridge 5. Social Security Number 6. Sex 7. Age (In yrs. last birthda) $10 \text{ M}  2       \text$	Sykesville    If Under 1 Year   If Under 24 Hrs. 8.	Date of Birth (Month Day, Year) Pr 11, 1916  Gair OII  9. Birthplace (State or Foreign County) CATTOII
١.	Director		Usual Residence of Decedent	A	p1 11, 1910 On
	Marylanda-f show	tor	MD 10a. State Carroll 10c. City, Town or I	Sykesville	10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	h with the 23a or 28i	Funeral Director	10e. Street and Number 710 Obrecht Road	10f. Zip Code 21784	10g. Citizen of What Country? USA
. 98	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or Items 23a or 28a-f show any injury or other traumatic avent, Ite Medicul Examinating to rolliked at 2008.	by Funer	11. Marital Status  1 Never Married 2 Married  3 \ Widowed 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 Yes 2 \ No II Yes 6 \ No II Yes Give Year or Dates:	Was Decedent of Hispanic Origin? (Specify If Yes, specify Cuban, Mexican, Puerto Rici	(Yes or No- an, etc.)  14. Race - American Indian, Black, White, etc.  Specify: White
9	2 hou	ted t	15. Decedent's Education 16a. Dec	edent's Usual Occupation	16b. Kind of Business/Industry
21215-0036	within 7 iene. than "n	Completed	(Specify only highest grade completed) (Giv life.	e kind of work done during most of working DO NOT use retired)  Registered Nurse	Health Care
	e filed within al Hygiene. I othar than vant, Ita Ma	Be Cc	17. Father's Name (First, Middle, Last)		irst, Middle, Maiden Surname)
Maryland	should be ind Mental markad o umatic ava	ToE	Louis Leathers	Mildred	
	and 2 sh ealth and n 27 Is n			•	oute Number, City or Town, State, Zip Code) icott City, MD 21042
Baltimore,	permit. Pages 1 and 2 Department of Health Important: If itam 27 any injury or othar tr. once.		1 Mauriai 21 Cremation 31 Hemoval from State 1	position (Name of Pate Place)  Cemetery 3/18/20	Zon double only or round order
Baltii	permit. Page Department of Important: If any injury or once.			ATGHI <sup>nd</sup> FUNERAL MOME & ykesville, MD 21784	
	Physician /Medical Examiner		23a. Part1. Enter the disease, or complications that caused the death. Do not enshock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a		
68760,	licate be executed physician and s the burial-transit	edical Examine	Sequentially list conditions, if any, leading to immediate cause. The control of the control of		
P.O. Box 68	death certii e attending id for use a	Physiclan/Med		□Ectopic pregnancy □ Other (specify)	23d. Date of delivery Month Day Year
	law requires that the as been signed by th 2 should be detache	þ	Part II. Other significant conditions contributing to death but not resulting in the End stage dementia	underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?  1  Yes  2 No 3 Probably 4 Unknown
Vital Records,	The ate h page	Completed	/		24a. Was an autopsy performed?  1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?  1 Yes 2 No
Vita	Physician: Th this certificate ral director, pag	o Be	25. Was case referred to medical examinar?  Hospital: Hospital:	26. Place of Death (C	
oţ	ding Phys h. After this funeral di	$\vdash$	1 ☐ Yes 2 ☐ Y	ol 28c. Injury at 28d	5 Residence 6 Other (Specify)  Describe how injury occurred
Division	l or Attanding after death. Diractor: After I in by the fune	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined 28e. Place of Injury At home, farm, s building, etc. (Specify)		Location (Street and Number or Rural Route Number, City or Town, State)
	Hospital 4 hours Funaral ely filled	edical C	29a. Certifier (Check only one)  1	ath occurred at the time, date and place, and nvestigation, in my opinion, death occurred a	due to the cause(s) and manner as stated. at the time, date and place, and due to the cause(s)
	To the within 2 To the Complet	Me	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
			VClin A ( Dal Salle 1)	1008258	Warch 10,2006
	15		Olum Albahalli 30 Name and address of person who completed cause of death (Item 23a), (Type Alva S. Baket 710 Object K	and Sykesville)	ND 21784
	Sta Registr		31. Date filed (Month, Day, Year)  32. Registrar's Signature	ule	

			1 - For Registrar	State of Marylar		ent of Health and late of Death		ene 006	07648
	*		1. Decedent's Name (First, Middle, Last,	1 1 .			2. Date of Death Month		3. Time of Death
	Physici /Medio		DWIGHT 1	McNair			Maach	Day 2006	7:35 AM
	Examir	er	4a. Fecility Name (If not institution, give	street and number)	4b. Cit	y, Town, or Location of Deat	h	4c. County of Deat	h /l
	Funeral		5. Social Security Number 6. Sec	7. Age (In yrs.	last birthday) If Und	SQ TIMOT ler 1 Year   If Under 24 Hrs	8. Date of Birth	9 Birt	hplace (State or Foreign
r	Funeral Director			M 20 F 52	Yrs. Month	s Days Hours Min.	8. Date of Birth (Month, Day,	1953 1/00	The Carplina
	pur M		Usual Residence of Decedent  10a. State 10b. County	10c Ci	ty. Town or Location		7	740	10d. Inside City Limits
	Maryle febo	ō	Manda A/A	100.0	20.14:100	200			1 X Yes 2 No
	death with the Maryland ms 23s or 28e-f ehow Litual be notified at	rect	10e. Street and Number	4	201 / 171	OI C Zip Code	10	g. Citizen of What Co	/ '
	th with	ai D	4020 N. RO	gers Aug	2 APTI TOTAL	21207		11 SA	
	tems	Funeral Director	11. Marital Status	12. Was Decedent Ever in L Armed Forces?	J.S. 13. Was Dec	edent of Hispanic Origin? (Specify Cuban, Mexican, Puer	pecify Yes or No- o Rican, etc.)	14. Race - Ame Black, White	
36	rs afte	by Fi	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	1 ☐ Yes	20 No Specify:		Specify: D	ac V
2-0036	be filed within 72 hours after death with the Marylar lat Hygiene. Id other than "natural", or Items 23e or 28e-f ehow other than "natural", or Items 23e or 28e-f ehow event, the Madical Examinat mast be notified at		15. Decedent's Edu	cation	16a. Decedent's Us		1	6b. Kind of Business/	Industry
21	ithin 7 ne. nen "r	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO NOT	vork done during most of wor use retired)	rking	T 1 11	12: 11:
2	iled w Hygier ther th	S	17. Father's Name (First, Middle, Last)		Anima	1 lechnic	ne (First, Middle, M.	lohns H	OPKINS Univ.
aŭ	d be f ental l ked of	To Be	Tr. I dellor 3 (valie (r nat, modio, 223t)			III F	a Paic		•
Maryland	should and Mer s marks umatic	F	19a. Informant's Name/Relationship (Ty	pe, Print) (SIS QF)	19b. Mailing Addre	ss (Street and Number or Ru			Zip Code)
	end 2 ealth a n 27 la		Ns. Wanda 1	acNair	4020	N. Bogers	Ave. AP	Balta	Md. 21207
0.0	ges 1 en it of Heal if Item 2 or other		20a. Method of Disposition  1 Burial 2 Cremation 3	20b.	Place of Disposition (A	rother place)	-1	oc. Location - City or	Town, State
Baltimore,	Pa ant ury		4 ☐ Donation 5 ☐ Other (Specify)	Mc	Leod & Mcl	Vair Cem. 3/13	12006 L	aurenb	jurg, N.C.
e P	permit. Departi Import any inj		21. Signature of Funeral Service Licens	. Russ	Jose 2222	W. North Au	Funera e. Balto	Home,	P. A.
			23a. Part   Enter the disease, or complished, or heart failure. List only or	cations that caused the dea ne cause on each line.	th. Do not enter the m	ode of dying, such as cardiad	or respiratory arres	t,	Approximate Interval Between Onset and Death
7	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)		ytosis				3 months
	Examiner			Due to (or as a consec	quence of): ON				3 months
		ner	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consec	quence of):	/			
	ecuted and transi	Examine	Cause (Disease or injury that initiated events resulting in death) Last		TRITTON	<b>/</b>			6months
8/60,	death certificate be executed e ettending physicien and id for use as the burial-transit		Toolaning in doubly 2000	CARDIO	ruence or): PULM D	NARY A	REST	-	5 minutes
200	tificate ig phy: as the	ledicai		-				30	
ž	leath certific ettending p I for use as	an/N	230. Was decedent pregnant	3c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Feta		pregnancy		23d. Date of deli	,
	the dea y the et tched fo	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at time of o				Month	Day Year
S,	w requires that the de been signed by the should be detached	by P	Part II. Other significant conditions cor	ntributing to death but not res	ulting in the underlying	cause given in Part I.	23e. Did toba	cco use contribute to	the cause of death?
Hecords,	nequir een si hould						1 Tes	2 □ No 3 □ Pro	obably 4 Unknown
ě	2 2 3	Completed					24a. Was an autopsy	24b. Were au	topsy findings available completion of cause of
VII	ate pag	e Co	25. Was case referred to medical				performe 1 ☐ Yes 2 〔	d? death? XNo 1 ☐ Yes	2 No
_	Physician: this certific	0 B	examiner?	ospital: 1 XInpatient 2	ER/Outpatient 3 []	Othor	ome 5 Residen	ce 6 Other (Spec	rife)
o L	ng Phys ter this neral di	n:	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how		,
SIO	tendii leath. tor: A the fu	catio	2 Accident investigation 3 Suicide 6 Could not be		М	1 ☐ Yes 2 ☐ No			
DIVISION	el or At s after d el Direct ed in by	Certification:	4 Homicide determined	28e. Place of Injury - At h building, etc. (Special	ome, farm, street, factory)	ory, office	28f. Location (Stre City or Town,	et and Number or Ru State)	ral Route Number,
	To the Hospital or Attending Phywithin 24 hours after death. To the Funerel Director: After thi completely filled in by the funeral	Medical (	29a. Certifier 1 Certifying Phys (Check only one) 1 Medical Exami	sician: To the best of my knoter: On the basis of examina and manner stated.	owledge, death occurre tion and/or investigation	d at the time, date and place on, in my opinion, death occu	, and due to the cau rred at the time, dat	se(s) and manner as and place, and due	stated. to the cause(s)
	To th within To th	Me	29b. Signature and title of certifier	11 01 01 00		9c. License number	290	I. Date signed (Monti	n, Day, Year)
,	0		Marchael	warry		AT 243894	16 1	larch 9	,2006
1	) \		30. Name and address of person who co	mpleted cause of death (Iter	n 23a) (Type, Print)	ATZ43890 Union Men	novial	Hasala	LMO
	Sta	te	31. Date filed (Month, Day, Year)	32 Registrar's Signa		rault Mel	110 7 1001	11001110	1/1-10
	Registr		MAR 1 4 2006	From A	Coaste )				

		ı	For State Registrar	State of Mary		partment of F			ene a. No2 0 0 6	07649
			Decedent's Name (First, Michael Control of the	dle, Last)			2	Date of Death		3. Time of Death
	Physici /Medio		Sally M	. Mulcahy			n	1 month 8	Hay 2006	2:35 PM
	Examir	er	4a. Facility Name (If not institut Boltimer W	ishington Mark		nter, C	, , ,	maria	4c. County of Deat	Drudel
	Funeral Director		5. Social Security Number 212-34-9790	6. Sex 7. Age (In	n yrs. last birthd Yrs	Months Davs	Hours Min.	Date of Birth (Month, Day, Y	(9. Birt 1936 Ma	hplace (State or Foreign untry) ryland
			Usual Residence of Decedent					,		
	after death with the Marylan or items 23a or 28e-f ehow infrer mart be coulded at	7	10a. State 10b. Cour Maryland Anne	'	oc. City, Town o Pasaden					10d. Inside City Limits 1 ☐ Yes 2 No
	the N	Funeral Director	10e. Street and Number			10f. Zip Code		100	g. Citizen of What Co	
	h with	a D	168 Meadow Ro	ad			21122		USA	
	ems 2	iner	11. Marital Status	12. Was Decedent Ever Armed Forces?	r in U.S.	3. Was Decedent of H	lispanic Origin? (Spec an, Mexican, Puerto Ri	fy Yes or No- can, etc.)	14. Race - Ame Black, White	
36	within 72 hours after death with the Maryland ene. than "natural", or items 23e or 28e-f ehow the Medical Examinar must be restlied at	by Fu	1 ☐ Never Married 2 ☑ M 3 ☐ Widowed 4 ☐ Divorc	If Yes Give		1 ☐ Yes 2 No	Specify:			White
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours Department of Health and Mental Hyglene. Importent: if Itam 27 Ie marked other than "natural; any injury or other traumatic event, the Medical Exa 20108.	ted	15. Deced	ent's Education hest grade completed)	16a. De	ecedent's Usual Occup	ation	16	6b. Kind of Business/	Industry
21	ithin 7	Completed	Elementary/Secondary (0-12		'iif	e. DO NOT use retired	d)			
42	be filed w stal Hygies of other ti		17. Father's Name (First, Middle	le. Last)		Homemaker	18. Mother's Name (		Own Home	
<u>a</u> nc	lid be lental ked o	To Be	Harry Det	-			Eleanor	F1y	nn	
ary	2 should and Menie marker		19a. Informant's Name/Relation	nship (Type, Print)	19b. M	ailing Address (Street	and Number or Rural	Route Number, (	City or Town, State, 2	?ip Code)
Z ×	and sealth m 27			cahy Jr. (Spous	THE RESERVE OF THE PARTY OF THE	B Meadow Ro	oad, Pasade	The second secon		
ore	ages 1 nt of H : if Ita			n 3 Removal from State	cemetery,	crematory or other plac	ce)		Oc. Location - City or	
Ę	artmer ortent injury		4 ☐ Donation 5 ☐ Other  21. Signature of Funeral S m		bayview	Crematory 22. Name and Addre		00 0	altimore,	Maryland
B	permit. Departrimporte		7/lane S.	blown		McCully-Po 3204 Mount	lyniak Fun ain Road,	eral Ho Pasaden	me P.A. a, Marylar	nd 21122
				or complications that caused the ist of y one cause on each line.					t,	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a	/	- Jan	Can	car		Chisti and Douth
	Examiner			Due to (or as a co	onsequence of):					
		Je L	Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a co	onsaquenne of):					
	acuted and transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c						
238	cate be executed physicien and tha burial-transit	ai Ex	resulting in coality Last	Due to (or as a co	onsequence or):					
7	ificate g phys as tha	edicai		d						
€ \$	death certific e attending p id for use as	M/ue	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of p 1 ☐ Live birth 2 ☐		3 ☐ Ectopic pregnancy	,		23d. Date of del	
	0 0	by Physician/Me	in the past 12 months? 1 ☐ Yes 2 M No 9 ☐ Unknown	4☐Pregnant at time 9☐ Unknown		5 Other (specify)			Month	Day Year
29	law requires that the d as been signed by the 2 should be deteched	y Ph	Part II. Other significant cond	itions contributing to death but no	ot resulting in th	e underlying cause giv	ren in Part I.	23e. Did toba	acco use contribute to	the cause of death?
∑ S	w requires that been signed to should be det	ed b						1 ☐ Yes	2 0 3 □ Pr	obabiy 4 Unknown
ecor	e lawre has bee ge 2 sho	Completed						24a. Was an autopsy	24b. Were au	stopsy findings available completion of cause of
25	ate pag	Con						autopsy performe	ed? death? No 1 ☐ Yes	100
S. Vital	ysician: Th is certificate director, pag	Be	25. Was case referred to medi examiner?	Hospital:		stront 20 DOA Ott	26. Place of Death			
\$ X	유유	ت: 1	1 ☐ Yes 2 No 27. Manner of Death	1 Inpatient 28a. Date of Injury (Month, Day Ye	2 ER/Outpa 28b. Tim	e of 28c. Injus	4 Indising Hom		ce 6 Other (Spectric)	oily)
ion	ttending I death. stor: After t the funer	atio	E Carrocacia	stigation	e <i>ar)</i> Inju		Yes 2 □No			
Division	- 9	Certification:	3 Suicide 6 Cou 4 Homicide dete	28e. Place of Injury building, etc. (5		, street, factory, office	28	of. Location (Stree City or Town,	eet and Number or Ru State)	ural Route Number,
٥	Hospitel	edical Co	29a. Certifier TS/Certif (Check only one)	ying Physician: To the best of m al Examiner: On the basis of examiner stated	amination and/o	leath occurred at the tier investigation, in my o	me, date and place, ar ppinion, death occurred	id due to the cau d at the time, dat	use(s) and manner as e and place, and due	stated. to the cause(s)
_	within 2 To the comple	Med	29b. Signature and little of cert	<del>\</del>		29c. Licens	se number	290	d. Date signed (Mont	h, Day, Year)
	N		1	(In 15		1)48	006	0	3/08/2	006
	1		KOFI B	on who completed cause of death	30)	Hospi.	feel for	165/	m Bm	and, mD
	Sta Regist	ate rar	31. Date filed (Month, Day, Ye MAR 1 4 20	ar) 32. Registrars	Signature			,		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene | | | | For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 8:000 2 2006 /Medical /4c. County of Death 4a. Facility Name (If not institution, give street and number 4b City Town or Location of Death Examiner If Under Birthplace (State or Foreign Country) (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** Months Days Hours Min. 1 M 2 F 13 Yrs ĞΑ 253.44.0928 Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10h County 10d Inside City Limits 10a State item 27 is marked other than "natural", or iteme 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at 1 X Yes 2 □ No Director NIA BALTIMORE MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? DRIVE 2138 EILICON WAY 21216 ABU Completed by Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ØYes 2 ☐ No 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 TYAS 20 No Specify: Specify: BLACK 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b, Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) MARINE 12/14 GRADE FEDERAL GOVERNMENT NA 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be and Mental H HARVEY MC KIEVER ADIA ROGERS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If Itam 27 Is any njury or other trainonce. EUGENE MCKIEVER (BROTHER) 110 WEST END AVE. \* IC NEW YORK NY 10025 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 

Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 Other (Specify) GARRISON FOREST 03.15.06 OWINGS MIUS. MD 22. Name and Address of Facility
VAUGHN C. GREENE FUNERAL SERVICE
5151 BALDO. NATL PIKE, BALTO. MD 21229 21. Signature of Funeral Service License anon 23a. Part 1. Enjoy the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or user tailure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner The law requires that the death certificate be executed use as the burial-transit resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy jo in the past 12 months? Day Month 4☐Pregnant at time of death 5 Other (specify) P.O. page 2 should be detached Š Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 3 Probably 4 Unknown 1 Yes 2 No Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 2 No 1 Yes the Hospital or Attending Physician: director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one examiner? 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 2 ER/Outpatient 3 DOA this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. 28d. Describe how injury occurred Injury at Work? 1 Natural 2 Accident Injury 5 Pending death. 1 ☐ Yes 2 ☐ No investigation within 24 hours after death To the Funerel Director: 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) δ 4 Homicide filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai completely (Check only one) 29b. Signature and title of certifier

State Registrar 31. Date filed (Month, Day, Year)

MAR 1 4 2006

DHMH 17 Rev 1/2001

3900 Lock Raven

2. Registrar's Signature

30. Name and address of person who impleted cause of death (Item 23a) (Type, Print)

3. Time of Death

10d. Inside City Limits

Approximate Interval Between Onset and Death

SEAS

Day

2 No

29d. Date signed (Month, Day, Year)

Year

1 ☐ Yes 2√ No

1:00° M

State

29b. Signature and title of pertifier

1CICHARD HEIZ 31. Date filed (Month, Day, Year) 32, Registrar's Signature MAR 1 4 2006

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

LOWERS

29c. License number

D025

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Pryor :45 PM erdella 2006 March 10 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimone
If Under 1 Year It Under 24 Hrs.
Months Days Hours Min. Ritchie NIA HUSPIE 5. Social Security Number 8. Date of Birth (Month, Day, Year) Aug w/14, 1960 Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1□M 211 F 216-88-8508 45 Yrs. Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: if item 27 is marked other then "naturel", or lieme 23a or 28s-1 show any injury or other treumatic event. In Medical Examples must be notified at once. 1 Pres 2 □ No Completed by Funeral Director Bultmore MO 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5544 21212 USH 12. Was Decedent Ever in U.S. Armed Forces? Midwood Was Decedent of Hispanic Origin? (Specify Yes or No-It Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: AFrican American 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Counselor Health 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ဥ Maggie marshall woods UNK 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5544 Milwood Ave Bultimore Dowg hten Jarmon MO 21212 Lawende 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 14200 Crematory Bultimon 21. Signature of Fune at Service Licensee 22. Name and Address & Facility
How Close Tune
5126 Belayn. Re al Service, P.A 00515 am. 23a. Part 1. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart tailure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ancei 5 Months /Medical Due to (or as a gonsequence of): Examiner Irm and brain Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine I or Attending Physicien: The law requires that the death certificate be executed filer death.

Director: After this certificate has been signed by the attending physicien and in by the fundard director, page 2 should be deached for use as the buriat-transit attending physiclen and for use as the burial-transit Due to (or as a consequence ot): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 Other (specify) P.0. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Division of Vital Records, 3 Probably 4 NUnknown 1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2☐ No 24a. Was an autopsy performed 2□No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death | Check only one Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No 2 Accident investigation To the Hospital or Atte within 24 hours efter de To the Funerel Directo completely filled in by the 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, tarm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Karnavine 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ZUteu 1. Hamson 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

State

Registrar

MAR 1 4 2006

State of Maryland / Department of Health and Mental Hygiene 07653 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** WILLIAM March 6, 2006 11:21 CULVERWELL McDONNELL. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 7111 Oxford Road Stoneleigh
Under 1 Year | If Under 24 Hrs.
On this Days | Hours | Min. Baltimore County
9. Birthplace (State of Poreign 8. Date of Birth (Month, Day, Oct 10, 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 216-20-7204 78 Maryland Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 ie marked other than "natural", or items 23a or 28a-f ehow other traumatic event, tre Medical Examinar must be notifiled at 1 ☐ Yes 2 💆 No Maryland Baltimore County Directo Stoneleigh 10f. Zip Code 10g. Citizen of What Country? Funerai 7111 Oxford Road USA Race - American Indian, Black, White, etc. 21212 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status '45-'48 <sub>1□ Yes 25 No</sub> within 72 hours after 1 MYes 2 □ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 🕅 Married 3altimore, Maryland 21215-0036 Specify: Specify: þ White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed withir Department of Health and Mental Hygiene. Important: If Item 27 Ie marked other than any Injury or other traumatic event, the Me College (1-4or 5+) Elementary/Secondary (0-12) Urban Planner Consulting 5+ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William C. McDonnell, Sr. Mary Regina Rice 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Constance E. McDonnell (Wife) 7111 Oxford Road, Baltimore, Maryland 21212 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Green Mount Crematory 3/8/2006 Baltimore, Maryland 21. Signatural Service Licensee 22. Name and Address of Facility
Mitchell-Wiedefeld Funeral Home, Inc. Martin D. Lawson 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, approximate language. Course (Tital) Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Arnythymic ardiac **Physician** /Medical Due to (or as a consequence of) Examiner vernic OUR Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the attending physicien and hed for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 5 Other (specify) page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۵ .5 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No Completed peen : 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy performed? res 2 No 1 ☐ Yes 2 No 1 Yes 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending s after death. 1 □Yes 2 □No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide To the Hospital o within 24 hours af To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie 2006 B 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7600 Osler Drive, Donna L. Dow, M.D., Suite 209, Towson, Maryland 21204

DHMH 17 Rev 1/2001

State Registrar

31. Date filed (Month, Day, Year)
MAR 1 4 2006

		• •	of Maryland / Depart Certif		•	2006 0765L
		Decedent's Name (First, Middle, Last)			2. Date of Death Month	3. Time of Death
	nysician Medical	DOROTHY		MANSH	MARCH 11	2006 9:01 A M
E	xaminer	4a. Facility Name (If not institution, give street and n		c. City, Town, or Location of Death	4	4c. County of Death
		SUBURBAN HOSPITAL  5. Social Security Number 6. Sex		BETHESDA Under 1 Year   If Under 24 Hrs.	O Date of Birth	MONTGOMERY
	neral ector	034-05-0107 Cusual Residence of Decedent		onths Days Hours Min.	8. Date of Birth (Month, Day, Yea 03/22/191	9. Birthplace (State or Foreign Country) MASS.
3 5 g	4	10a. State 10b. County	10c. City, Town or Locati	on		10d. Inside City Limits
O A Par	i i	PA MONTGOMERY	ELKINS PARK	<		1 Tes 2 No
	be natilled Director	10e. Street and Number		0f. Zip Code	10g. C	Citizen of What Country?
500	ra	100 BREYER DRIVE		19027		U.S.A.
`` O :	hiner must Funeral	11. Marital Status 12. Was De Armed F	cedent Ever in U.S. 13. Was orces?	Decedent of Hispanic Origin? (Sp is, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.
36 rs aft	by F	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes If Yes, © Year or	2 No live X 1 □	Yes 21 No Specify:		Specify: WHITE
2 hou	ted ted			's Usual Occupation d of work done during most of work	16b.	Kind of Business/Industry
1215 within 7	Mardi	(Specify only highest grade completed Elementary/Secondary (0-12) College	(Give kind (1-4or 5+)	d of work done during most of work NOT use retired)	ing	,
nd 2121	t, the Medical	4	TEACHER	<b>(</b>	C	HILD CARE CENTER
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours att Doparmant of Health and Mental Hygiene.	: 6	17. Father's Name (First, Middle, Last)	CARRO		e (First, Middle, Maide	өп Sumame) HANDVERGER
Aard and and	e e	19a. tnformant's Name/Retationship (Type, Print)		ddress (Street and Number or Rui		
E, N and tealth	, per		NSH 1454 S 20b. Place of Disposition	CHIRRA DRIVE -		PA. 19002
Tor India	0	20a. Method of Disposition  1 Burial 2 Cremation 3 Removal from	n State cemetery, cremato	nry or other place)		Location - City or Town, State
Baltimore,	ž.	4 Donation 5 Other (Specify)  21. Signature of Funeral Service Licensee	MONTEFIORE		2/2006 ABI	
Ba Ba	eny i	21. Signature of Purieral Service Licensee				& BROS., INC.
		23a. Part1. Enter the disease, or complications that shock, or heart failure. List only one cause on	caused the death. Do not enter the	NU_REISTERSTUWN  ne mode of dying, such as cardiac	Or respiratory arrest.	FSVILLE, MD 21208 Approximate
Phys	oian	Immediate Cause (Final				Interval Between Onset and Death
Physi /Me	dical		ARDENOSDESOTIC   For contract of the contract	IEART DISEASE		
Exam	niner					
T)	ner ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated evenits c.	(or as a consequence of):	···········		
oute A	rial-transit					
760, te be exe	3 -	Due to	o (or as a consequence of):			
- W :	( <u>0</u>	d				
Records, P.O. Box 68 The law requires that the death certifical	etached for use as the behaviorally by sician/Medica	IF FEMALE: 23c. If yes o	utcome of pregnancy			22d Date of delivery
Box leath cert	rforu	23b. Was decedent pregnant in the past 12 months?	birth 2 ☐ Fetal death 3 ☐ Ec	opic pregnancy her (specify)		23d. Date of delivery  Month Day Year
P.O.	detached t	1 ☐ Yes 2 🕅 No 9 ☐ Unknown 9 ☐ Unk				
s thet	d be deta	Part II. Other significant conditions contributing to	death but not resulting in the unde	lying cause given in Part I.	23e. Did tobacco	o use contribute to the cause of death?
rds quire	should b	CONGESTIVE HEART FAILURE			1 ☐ Yes	2 No 3 ☐ Probably 4 ☐ Unknown
O S S	page 2 should				24a. Was an	24b. Were autopsy findings available prior to completion of cause of
The I	rector, page 2 s				autopsy performed? 1 ☐ Yes 2 ☑ N	death?
is is is is is is is is is is is is is i	Be (	25. Was case referred to medical examiner?		26. Place of Deal	h (Check only one)	
of Vita Physician:	To To	1 ☐ Yes 💥 ☐ No Hospital: 1 ☐	Inpatient 2 X ER/Outpatient		ome 5 Residence	6 ☐Other (Specify)
on o	unera On:	1 X Natural 5 □ Pending (Mo	of Injury 28b. Time of Injury Injury	28c. Injury at Work?	28d. Describe how in	jury occurred
Vision Attending	the	2 Accident investigation 3 Suicide 6 Could not be		M 1 Yes 2 No	COS I continu (Channel	
Division of Vital Records, for Attending Physician: The law requires that after death.	ed in by the funera	4 Homicide determined 28e. Plac	e of Injury - At home, farm, street, ding, etc. (Specify)	Ta Clory, Office	City or Town, Sta	and Number or Rural Route Number, ate)
Division of Vita Vita Hospital or Attending Physician: within 24 hours after death within 24 hours after death of the contribution of the contribu	E C	29a. Certifier 1 ☑ Certifying Physician: To the	ne best of my knowledge, death oc	curred at the time, date and place	and due to the cause	(s) and manner as stated.
Ho Ho	mpletely fill	(Check only 2 Medical Examiner: On the	basis of examination and/or invest nner stated.	igation, in my opinion, death occur	red at the time, date a	and place, and due to the cause(s)
To th	E COMP	29b. Signature and title of certifier		29c. License number	29d. E	Date signed (Month, Day, Year)
		, , , ,	10	55410	Lu	oca 11,200/
1	2	30. Name and address of person who completed car Yevgerny Grace	use of death (Item 23a) (Type, Prin	Bu bushan		
R	State egistrar		Registrar's Signature	di		

DHMH 17 Rev 1/2001

ORIGINAL

MARCH

			1 - For State Registrar	State of M	aryland / Dep	ertificate of	lealth and i	Mental Hy	giene	ं ।	07656
	Obvoisi		1. Decedent's Name (First, Middle,	A / 1	ν,	1 - 1 -		2. Date of De Month	ath Day	Year	3. Time of Death
	Physici /Medic		Rose	Wlari	e II	le Isa		March	133	00°C	155AM
	Examir		4a. Facility Name (If not institution,	give street and number)	20 50 70=	4b. City, Town, o	r Location of Death		4c. County	of Death	
			Johns Hopkus	sone a	DECOVED.	BOTH.			BOUT	amo	re City
	Funeral			3. Sex 7. Ag	e (In yrs. last birthda)	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da Sept. 27	th y, Year)	9. Birthpl	ace (State or Foreign try)
	Director		214-26-8126 Usual Residence of Decedent	10101 2521	75 Yrs.			Sept.27	, 1930	Mary	1and
	and		10a. State 10b. County		10c. City, Town or I	ocation				10	Od. Inside City Limits
	/anyl	ō	M11							"	1 √ Yes 2 No
	28a-	ect	Maryland n/a		Baltin	10f. Zip Code			40= Chiese +414	(11-0	<u> </u>
	with e or	Ö		_			06		10g. Citizen of V		•
	eath	by Funeral Director	5301 Sipple Av	12. Was Decedent	Ever in IIS 13	Was Decedent of H		nanifu Van ar Na	United S	State • America	
10	iter d	T'un	1 ☐ Never Married 2 ☐ Marrie	Armed Forces?	No.	. Was Decedent of H If Yes, specify Cuba	an, Mexican, Puert	o Rican, etc.)	Blac	k, White, e	
336	urs al	by	3XXWidowed 4 □ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes XX No	Specify:		Specify	Whi	to
21215-0036	filed within 72 hours after death with the Maryland Hygiene. ther then "natural", or items 23e or 28e-f show the the Medical Exandrat must be indiffed at	ted	15. Decedent's	Education	16a. Dec	edent's Usual Occup	ation		16b. Kind of Bu		
215	hin 7	Completed	(Specify only highest Elementary/Secondary (0-12)	grade completed)  College (1-4or	life	e kind of work done o DO NOT use retired	during most of wor d)	king	Saint A		*
21;	filed with Hygiene. ther ther	mo	12 years	n/a		istrated A	Assistant		School		-9
	othe vent,	BeC	17. Father's Name (First, Middle, L	est)			18. Mother's Nan			θ)	
<u>a</u>	should be nd Mental marked c	ToE	Walter J. Oster	ling, Sr.			Agnes M	. V1k			
Maryland	2 sho and h is ma		19a. Informant's Name/Relationshi	(Type, Print)	19b. Mai	ling Address (Street	and Number or Ru	ral Route Numbe	er, City or Town,	State, Zip	Code)
	1 and 2 Health em 27 i		Cheryl Ann Nelso	n (Daughter	) 5301	Sipple A	ve. Balt:	imore. M	laryland	2120	6
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importement of Health and Mental Hygiene. Importement if item 27 is marked other then "natural", or Items 23e or 28e-1 show any injury or other treumatic event, the Medical Examinating the indifficular any once.		20a. Method of Disposition		20b. Place of Disp	osition (Name of ematory or other place		Date	20c. Location -		
Ĕ	Pages nent of I int: if its iry or o		1		Md. Vete	rans Cem.	3-16-	-2006	Crownsv	ille,	Maryland
alti	permil. Pag Department Importent: i eny injury o		21. Signature of Funeral Vervice L	cons	1,3	2. Name and Addres	ss of Facility				
m	Depa Impo eny ii		J	. Wayne Ost	erling 2	2. Name and Address IcCully-Po 37 E. Pat	lyniak Fi	uneral H e Ralti	lome. P.A	A. 21	225
	7		23a, Part 1. Enter the disease, or of shock, or heart ailure. List of		the death. Do not er	nter the mode of dyin	g, such as cardiac	or respiratory a	rest,	21	Approximate
	Pnysician		Immediate Cause (Small	ny one cause on each	-	(	1				Interval Between Onset and Death
	/Medical		disease or con ition resulting in death)	a. Due to (or as	a consequence of):	00	1 Tuli				pom?
	Examiner										
		ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as	a consequence of):						
	uted d ansit	Examiner	that initiated events							- 12	
oʻ	be executed sician and burial-transit	Exa	resulting in death) Last	Due to (or as	a consequence of):						
8760,	The law requires that the death certificate be executed tte has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Medical		d							
9	tifica ng ph as th	led			-						
Вох	eath certif attending for use as	7	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome					23d. Date	e of deliver	ry
	death e atte	lcia	in the past 12 months?	4☐Pregnant a		□Ectopic pregnancy □ Other ( <i>specify</i> )			Mor	nth I	Day Year
Ö.	t the by th tache	hys	9 Unknown	9□ Unknown							
σ,	res that the de signed by the a l be detached t	by P	Part II. Other significant condition	s contributing to death b	ut not resulting in the	underlying cause give	en in Part I.	23e. Did to	obacco use contr	ibute to the	e cause of death?
rd	w require been sig should b	ed t	Respiration	4-Foul	00 on	Fullo	tie	10	res 🔪 No	3 🔲 Proba	abiy 4 🗆 Unknown
Records,	s bee	Completed	Rocinant		dina	1. E. c.	10	24a. Was	an 24b. V	Vere autop	osy findings available
E	The lay te has age 2	mo	070		1 -1	Chint-	110		rmegl? d	eath?	npletion of cause of
Vital		0	25. Was case referred to medical	Suro-t	4000	cospect	26. Place of Dea	1 Yes		□Yes	2. <b>X</b> No
>	Physicien: this certificatal director,	OB	examiner? 1 ☐ Yes 2 No	Hospital:	ent 2 ER/Outpatie	ont 30 DOA Oth	00		dence 6 Othe	or (Canaik	1
of	P = E	n: 1	27. Manner of Death	28a. Date of Inju (Month, Da					now injury occurr		<i>!</i>
lon	th. :: Afte	atio	1XNatural 5 ☐ Pending 2 ☐ Accident investiga		y Year) Injury		k? Yes 2 □No				
Division	Attendir death, ector: A by the fu	iffice	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	ed   28e. Place of Inj	ury - At home, farm, s	treet, factory, office			Street and Number	er or Rural	Route Number,
Ö	el or A s after il Dire	Certification:	4 Trofficide	building, et	c. (Specify)			City or Tov	vn, State)		
	nours nours nere		29a. Certifier 1 Certifying	Physician: To the best	of my knowledge, dea	th occurred at the tim	ne, date and place	, and due to the	cause(s) and ma	nner as sta	ated.
	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the funer	Medical	(Check only 2 ☐ Medical E one)	caminer: On the basis o and manner st	t examination and/or i	nvestigation, in my o	pinion, death occu	rred at the time,	date and place, a	ind due to	the cause(s)
	To the within To the comp	Me	29b. Signature and title of certifier	00	_	29c. License	e number		29d. Date signed	(Month, E	Day, Year)
	/.		11/3	( ) >	-out	1)	438	3 1	March 1	4.2	-006
1			30. Name and address of person w	no completed cause of c	leath (Item 23a) (Type	, Print)				,	2
	l '		Jernifer Fort		pkins is	Print)	Circle	FLOC	wore,	Son	1/ar 3/37A
	Sta	te	31. Date filed (Month, Day, Year)	32. Registr	ar's Signature						0190
	Registr	ar	MAD 1 / 21	INS PRODUCE	is Ass	affect of					

Amend item #11, perint, 654, 4///6 IT State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** 2006 Nordman March 12 1:25 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner GREATER BALTIMORE MEDICAL CENTER TOWSON BALTIMORE If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. 0ct. 26, 1917 6. Sex 1 ☑ M 2 ☐ F 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days New York 88 Director 099-12-4691 Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits or items 23a or 28a-f show other traumatic avent, the Medical Examiner must be notified at 1 Yes 2 No Funeral Director Baltimore Lutherville LOMAN, EDWARI 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? USA 21093 300 W. Seminary Avenue 12. Was Decedent Ever in U.S. Amed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 2 Married 1 ☐ Yes 2 No Specify: Completed by 3 ☐ Widowed 4 🛣 Divorced white Year or Dates "natural" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) filed withi Hygiene. Pipe Fitter Utility 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Gustaf Emil Nordman Mary Udele Korpi 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Depertment of Heelth and Important: if Itam 27 ia n any injury or other traun once. 316 Meadowcroft Lane; Lutherville, MD 21093 George Kline friend 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Durial R Cremation 3 Removal from State 4 □ Donation \ 5 □ Other (Specify) Garrison Forest MDVA 3/16/06 Owings Mills, MD 21. Signature of Funeral Service Lig 22. Name and Address of Facility 1050 York Road Towson, MD 21204 Ruck Towson Funeral Home Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one gause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Pheumonia 2 days /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a mansequence of) Hospital or Attending Physician: The law requires that the death certificate be executed physicien and the burial-transit Exami Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾ 1 | Yes 2 2 No 3 | Probably 4 | Unknown Be Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 2 3 No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner a Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification; Injury 1 Inatural 5 Pending 1 Yes 2 No death. i Director: / investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a 29a. Certifier 1 crifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check with 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 3/13/06 Som 01 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) St 54550 6535 Bulhouse MB N. Charles

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

MAR 1 4 2006

3. Registrar's Signature

Ba 1550

06-1749 B.K.S Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Unpend item# 23a, 27,28a-f, pen/E, 8553,3/2//00 II
State of Maryland / Department of Health and Mental Hygiene JOEL C. NELSON 1 - For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** Joel Cecil Nelson MARCH 11, 2006 0552 /Medical 4c. County of Death CARROLL 4a. Facility Name (If not institution, give street and number) Examiner CARROLL HOSPITAL CENTER | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Min. | Jan. 5. Social Security Number 7. Age (In yrs. last birthday) 20 Yrs. 9. Birthplace (State or Foreign County) Mary Land 6. Sex **Funeral** 214-13-5033 10 M 2□ F Director Usual Residence of Decedent with the Marylend permit. Pages 1 end 2 should be filed within 72 hours after deeth with the Maryler Department of Health and Mental Hygiene. Important: if item 27 is marked other then "naturel", or iteme 23a or 28a-f show empt fujury or other treumetic event, the Maxical Expraint rount be rutified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐Yes 2 ☐No Director Maryland Carroll Hampstead 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3333 Falls Rd. 21074 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Autobody Worker Collision Repair 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charles L. Nelson Joetta L. Roberts ဂ 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joetta L. Nelson - mother 3333 Falls Rd. Hampstead, Md. 21074 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1- Burial 2 □ Cremation 3 □ Removal from State St. Peters Church Cem. March 15,2006 4 □ Donation 5 □ Other (Specify) Hampstead, Md. 21. Signature of Funeral Service Licensee EZRAGAN AND PROPERTY 3296 Charmil Dr. Chapel P.A. Manchester, Md. 21102 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Acute alcohol intoxication /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, I any, leading to minimize acause. Enter Underlying Cause (Disease or injury Dualto (or as a consequence of): Examiner To the Hospital or Attending Physicien: The law requires that the death certificate be executed within 24 hours effer death.
To the Funeral Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director. Deap 2 should he detached for the completely filled in by the funeral director. that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, by Physician/Medical 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☑ Yes 2 ☐ No 24a. Was an 10 Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ▼ER/Outpatient 3 ☐ DOA ဥ 11 Yes 2 □ No 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred Certification: 1 Natural 5 Pending Fnd 3/11/2006 Fnd 5:04 AM 1 ☐ Yes 2 🕅 No 2 Accident investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1940 Hanover Pike Apt. B Carroll County, MD 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide found in dwelling 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

\*\*Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E MARCH 11, 2006 mis 3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LING mits LI 111 PENN STREET, BALTIMORE, MARYLAND 21201 32. Registrar's Signature 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

State Registrar

			1 = For State Registrar	State of N	Marylan		artmen rtificate			and M		giene Reg. No.	<b>J</b> U6	076	59
	Physici /Medic	al	1. Decedent's Name (First, Middle HARRY				NUSSB				2. Date of Dea Month MARCH	Day 9	2006	3. Time of 12:00	
	Examin	er	4a. Facility Name (If not institution						Location o	of Death			ounty of Death		
	<u> </u>	-	JEWISH CONVALE 5. Social Security Number			last birthday)	BAL If Under		If Under	24 Hrs.	8. Date of Birt		BALTIM 9. Birth	JKE nplace (State or untry)	Foreign
	Funeral Director		096-12-1842	1 M 2 □ F	84		Months	Days	Hours	Min.	8. Date of Birt DEC 29	1921	Coi	intry) N'	Υ
	pu »		Usual Residence of Decedent  10a. State 10b. County		10a Cib	y, Town or Lo	costion							10d. Inside Cit	v Limite
	shov	5		LTIMODE	100.00									1 TYes	-
	28a-1	rect	MD BA	LTIMORE		DALI	I MORE					10g. Citize	n of What Co		^
	3a or		7203 ROCKLAND	HILLS DRIVE	#101				212	209				USA	
	ier death with the Marylan Iteme 23a or 28a-f show	Funeral Director	11. Marital Status	12. Was Deceder	nt Ever in U.	S. 13.	Was Deced	dent of Hi	ispanic Ori	gin? (Sp	ecify Yes or No Rican, etc.)	- 14	Race - Amer Black, White		
98	72 hours after death with the Maryland natural; or Iteme 23e or 28e-f show deat Evarument to notified at		1 Never Married 2 Marr	ned 1 👿 Yes 2 [ If Yes, Give	□No WW	VI I	1 ☐ Yes		Specify:	.,	, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		pecify:	WHITE	
Ö	72 hours afte "natural", or l	ed by	3 Widowed 4 Divorced	Year or Dates t's Education	s: NA	1	dent's Usua	Al Occup	ation			16h Kind	of Business/I		
5	⊆ ہے ⊇	plete	(Specify only highes	st grade completed)	-5.)	(Give	kind of wo	rk done d	during mos	t of work	ing	TOD. TAITE	01 00311103341	ildustry	
21215-0036	d within giene. or then "	Completed	Elementary/Secondary (0-12)	College (1-4o	ir 5+)	SUPE	RVISO	R				TRAN	SPORTA	TION	
	be filed tal Hygi d other event, I	Be C	17. Father's Name (First, Middle,	Last)							e (First, Middle,	Maiden S	umame)	(11111111111111111111111111111111111111	٥ ١
Maryland		ပ	ABRAHAM				BAUM			THER			-	(UNKN	OWN)
Mar	d 2 should th and Mer 7 le marke treumatic		19a. Informant's Name/Relations SHIRLEY NUSSB				-				a <i>l Route Numbe</i> RIVE #10				2120
	1 an Heal em 2 ther		20a. Method of Disposition	AUN / WITE	20b. P	lace of Dispo	osition (Nan	ne of	I		Date		ation - City or		2120
nor	00		1 X Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S		(8)	emetery, cie RO KOD			1	-1 -	3/12/06	RAI.	TIMORE	MD	
Baltimore,	permit. Pag Depertment Important: I any injury o		21. Signature of Juneral Septice		PILIC	1	2. Name an				LEVINS				
m	im per		1 /ast		_	8	900 R	EIST	ERST		ROAD - J				08
			23a. Part1. Enter the disease, or shock, or heart fallare. List	complications that caus only one cause on each	ed the deat									Approximate Interval Betv	veen
	Physician		Immediate Pause (Final disease or condition	END S	STAGE	COLON	CANCE	R						Onset and D	eath
	/Medical Examiner		resulting in death)	Due to (or a	as a conseq	uence of):									
		<u>.</u>	Sequentially list conditions,	b. Due to for	as a conseq	uanca oth			·						
V	rted nsit	ulu u	cause. Enter Underlying Cause (Disease or injury	<											
Ć,	e be executed /sicien and e burial-transit	Examiner	that initiated events resulting in death) Last	Due to (or	as a conseq	uence of):									
8760,	The law requires that the death certificate be executed ate hes been signed by the attending physicien and page 2 should be detached for use as the burial-transit	cal		d											
9	artifica ing ph e as th	Med	IF FEMALE:											-	
Вох	eath certific attending pl	Physician/M	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcom	2 Feta	Ideath 3	⊟Ectopic pr					23	<li>d. Date of deli Month</li>	-	ear
o.	at the de by the a rached	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4⊡Pregnant 9⊡Unknown		eam 5	Other (sp	secity)							
Δ.	that the phase of		Part II. Other significant condition	ons contributing to death	but not res	uiting in the u	underlying o	ause giv	en in Part I		23e. Did t	obacco use	e contribute to	the cause of de	eath?
rds	quires in sign uld be	ed by									10,	Yes 2□	No 3∏Pro	obably 4	nknown
Records,	aw request been 2 shoul	Completed									24a. Was		24b. Were au	topsy findings a completion of ca	available
Ä		E O										rmed?	death?	2 □ No	1039 01
Vital	Physician: 1 rthis certificat ral director, pi	Be (	25. Was case referred to medica examiner?						-	of Deat	h (Check only o	ле)			
of \	Physi this c	၉	1 Yes 2 X No			ER/Outpatie			AMILIA	ursing Ho	ome 5 Resident			erfy)	
	Jing After fune	tlon	1 X Natural 5 ☐ Pendir	28a. Date of li (Month, i	Day Year)	28b. Time o Injury	M Z	28c. Injun World	ya≀ k? Yes 2	No	28d. Describe	now injury	occurred		
Division	Attending in death.  octor: After by the fune	flca	3 ☐ Suicide 6 ☐ Could	not be 28e, Place of	Injury - At he	ome, farm, st							Number or Ru	ral Route Numi	ber,
Š	el or safter	Certification:	4  Homicide determ	building,	etc. (Specif	(y)					City or To	wn, State)			
	To the Hospitel or Attent within 24 hours after death To the Funerel Director: completely filled in by the	Medical (		ng Physicien: To the be Exeminer: On the basis and manner	of examina										
	To the comp	×	29b. Signature and title of certifie	Ampian	7 1	40	296		9 <i>0</i> 6	31	74		signed (Month		
-	\$		30. Name and address of person Brahim Ele	who completed cause of	of death (Iter	-	9, 6h	10	an v	ale	74 escen	+ C	ente	T	
	Sta Regista		31. Date filed (Month, Day, Year) MAR 1		strar's Signa	ature	host	9							

State of Maryland / Department of Health and Mental Hygiene [] [] [ 07660 State Registrar Amend Item #20b Per FH G853 C3/11/1998 911 Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Physician MARCH Pay 2<sup>8</sup>06 01:10AM Annie W. O'Hara /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner TOWSON

If Under 1 Year | If Under 24 Hrs. | BALTIMORE GREATER BALTIMORE MEDICAL CENTER 8. Date of Birth (Month, Day, Year) Sept. 14, 9. Birthplace (State or Foreign Country)
New York 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Funeral Days Hours 1 M 2 XF 216-48-0907 81 Director Usual Residence of Decedent 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location r than "natural", or iteme 23s or 28s-f show the Medical Examinar must be notified at 1 ☐ Yes 2 No Director MD Baltimore Glen Arm 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21057 11630 Glen Arm Road Unit 255 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ②No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married White ie marked other than "natural", or 1 ☐ Yes 2 ☐ No Specify: 2 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Nurse Medica1 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) outd be f Mental } William W. Walker E. Lillian Carrington 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 ie
any injury or other trau John J. O'Hara, III (son) 3 Muirfield Court Lutherville, MD. 20a. Method of Disposition
1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 3/10/06 Hilltop Svc. Corp. 03/09/2006 Towson, Maryland ☐Donation 5 ☐ Other (Specify) ignature (Fyndial Service Licensee 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road, Towson, Maryland Stephen D. Coster

1000 101 k Rodu, 1000011, 1001

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Stephen D. Coster Approximate Interval Between Onset and Death tmmediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): **Physician** alam /Medical Examiner rale Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last bowlemna. The law requires that the death certificate be executed attending physicien and for use as the burial-transit Due to (or as a consequence of): Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) signed by the a Division of Vital Records, P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. monoma 1 Yes 2 No 3 Probably 4 □Unknown certificete has been si irector, page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy 1 Yes 3/2 No within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hosoital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Yes 1 Impatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Chatural 28b. Time of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 🗀 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide ö To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. License number D 30 4 3 29b. Signature and title of certifier M. DALY D 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

			State of Maryland 9d per Dr., G	553.63A	After the off	Death			U	07001
Physic	ian	Decedent's Name (First, Middle, Last)	_				2. Date of Dea Month		Year	3. Time of Death
/Medi		Robert Hutchins Pea	arre, Sr.				March	7, Day 2006		8:47 A N
Exami	ner	4a. Facility Name (If not institution, give sti				or Location of Death		4c. County o		
		Gilcrest Center for S. Social Security Number 6. Sex	or Hospice Ca		Baltin		8. Date of Birt			more
Funeral Director		214-18-6654	M 2□F 83	Yrs.	Months Days		(Month. Day	y, Year) 5, 1922	Coun	lace (State or Foreig htry) 'Land
and *		Usual Residence of Decedent  10a. State 10b. County	10c. City	, Town or Loc	ation				1	0d. Inside City Limits
/anyli	ō	MD Howard		1arksv:						1 ☐ Yes 2 🔀 No
with the Maryland a or 28a-f ehow	Director	10e. Street and Number		Laiksv.	10f, Zip Code		· · · · · · · · · · · · · · · · · · ·	10g. Citizen of W	hat Coun	ntry?
th with 23a or	0	5900 Whaleboat Dr.	unit # 205		21029			United		•
ne 23s	Funeral		. Was Decedent Ever in U.S	6. 13. W	as Decedent of I	Hispanic Origin? (Spe	ecify Yes or No-	14. Race	- Americ	an Indian,
be filed within 72 hours after death with the Maryland tal Hygiene. d other than "natural", or iteme 23a or 28a-f show event, the Madical Exeminar must be mailtied at		1 Never Married 2⊠ Married	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give	1	Yes, specify Cub □Yes 2⊠ No	san, Mexican, Puerto Specify:	Rican, etc.)	Black Specify:	, White,	
72 hours "natural", idical Exp	ed by	3 ☐ Widowed 4 ☐ Divorced  15. Decedent's Educa	Year or Dates:		nt's Usual Occu		- 1	16b. Kind of Bus		ite
in 72	Set	(Specify only highest grade	completed)	(Give k		during most of worki	ng	TOD. TAILS OF DAS	111033/1110	dustry
be filed within 7: tal Hygiene. d other than "n event, ine Mad	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	Fire :	Fighter			Baltimo	re c	ity gov't
othe othe vent,	Be	17. Father's Name (First, Middle, Last)				18. Mother's Name			)	
	70	Charles Buckey Pear	rre, Sr.	1			Hutchin			
s 1 and 2 should I Heelth and Mer Item 27 ie marke other treumatic		Phyllis Pearre / W:				t <i>and Number or Rura</i> at Dr unit				
permit. Pages 1 and 2 Depertment of Heelth a Important: if item 27 is eny injury or other tre <u>once</u> .	1	20a. Method of Disposition	20b. Pl	ace of Dispos	tion (Name of		Date	20c. Location - 0		
Pages nent of ant: if it		1 ☑ Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)			atory`or other pla rk Cemet	ery 3/11	/2006	Baltimor	e. M	arvland
ertme ontar injur		21. Signature of Funeral Service Licenses				ess of Facility Am				
permit. Depertr imports eny inje		Jean Do	V WALL	13	28 Sulph	mr Spring	Rd Arb	utus, Ma	ryla	nd 21227
		23a. Part1. Enter the disease, or complications shock, or heart failure. List only one	ations that caused the death	. Do not ente	the mode of dy	ing, such as cardiac o	or respiratory ar	rest,	1000	Approximate Interval Between
hysician		Immediate Cause (Final disease or condition	Anystroh	in Cart	nal Sci	eusi,			1	Onset and Death
/Medical		resulting in death)	Due to (or as a consequ	-						girs
caminer		Savuration list resolutions b.								
sit	iner	Sequentially list conditions b. if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	Due to (or as a consequ	ence of):						
sicien and burial-transit	Examine	that initiated events c. resulting in death) Last	Due to (or as a consequ	ence of):						
icien buria	a E		200 10 (01 00 0 00113540	31100 017.						
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ettending p	/We	IF FEMALE: 23b. Was decedent pregnant 23	c. If yes, outcome of pregnar					23d. Date	of delive	ory .
	iciai	in the past 12 months?	1☐Live birth 2☐Fetal 4☐Pregnant at time of de		ctopic pregnand Other <i>(specify)</i> _	су		Mon		Day Year
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yned bedeat	by Physician/Me	Part II. Other significant conditions conti	ributing to death but not resu	lting in the un	lerlying cause gr	ven in Part I.	23e. Did to	obacco use contri	oute to th	ne cause of death?
been sign should be	ed						101	res 2 X No	3 🗌 Prob	ably 4 Unknown
a se s	Completed						24a. Was	an 24b. W	ere autor	psy findings available mpletion of cause of
	Į.						perfo	rmed? de 200 No 1	eath? ☐ Yes	2□ No
certificate	Be (	25. Was case referred to medical examiner?				26. Place of Death	Check only o	ne)		
r this certific	2	1 ☐ Yes Ž∏ No Ho		ER/Outpatient	3 L DOW	her: 4 Nursing Ho				mospice
i e i	0	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Inju	ork?	28d. Describe h	now injury occurre	d	
death.	cat	2 Accident investigation 3 Suicide 6 Could not be	CO - Disea of laire Alba			]Yes 2□No	296 Logotion /6	Street and Numbe	D	1.Daylanda
e i i	Certification:	4 Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	)	эт, тастогу, опісе		City or Tox	vn, State)	r or mura	ii rioule Number,
ours ours illed	a C	29a. Certifier 1—Sertifying Physi	cian: To the best of my know	wledge, death	occurred at the t	ime, date and place,	and due to the	cause(s) and man	ner as st	tated.
	ledical	(Check only 2 Medical Examine one)	ar: On the basis of examinat and manner stated.	ion and/or inve	stigation, in my	opinion, death occurr	ed at the time,	date and place, a	nd due to	the cause(s)
To the within 2 To the comple	Σ	29b. Signature and title of certifier	_		29c. Licen	se number		29d. Date signed		-
(10)	1	Mulan	(m)		DS	8303	-1	Warch !	Marc	h 7, 2006
110	1	30. Name and address of person who com	own 660( N	23a/ (Type, P	rint)	BARRINO	, wo	21204		
		31. Date filed (Month, Day, Year)				17101010101				
St: Regist	ate	MAP 1 4 2006	32. Registrar's Signal	Roselle	9					

			. 101	rtment of Health and Mental tificate of Death	Hygiene () ()	07662
	Physici /Medic		1. Decedent's Name (First, Middle, Last)	2. Date of Month	Day Y	3. Time of Death
	Examir		4a. Facility Name (If not institution, give street and number)  Genesis Wentworth  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	4b. City, Town, or Location of Death Baltimore	4c. County of Balti	
	Funeral Director		458-16-0934 1□ M 2√X F 88 Yrs. Usual Residence of Decedent	Jan 2	of Birth 9	Country) unk
	sa-f show	Director	10a. State			10d. Inside City Limits 1 ☐ Yes 2☐ No
	ath with the 23 a or 2	ral Dire	1801 Wentworth Road	10f. Zip Code 21234		SA
980	72 hours after death with the Maryland natural; or items 23s or 28s-1 show disal Evant ar must be calified at	by Funeral	1 Never Married 2 Married 1 Yes 2 No	Vas Decedent of Hispanic Origin? (Specify Yes of Yes, specify Cuban, Mexican, Puerto Rican, etc.  ☐ Yes 2∏ No Specify:	or No- L) 14. Race - Black, ' Specify: W	American Indian, White, etc. 7hite
Maryland 21215-0036	within ane. than "	Completed	(Specify only highest grade completed) (Give k	ent's Usual Occupation kind of work done during most of working OO NOT use retired)	k 16b. Kind of Busin	ness/Industry unk
/land	2 should be filed and Mental Hygie and Mental Hygie Is marked other aumatic event, I.	To Be C	17. Father's Name (First, Middle, Last)	unk 18. Mother's Name (First, Mi	iddle, Maiden Sumame)	unk
	and 2 shou ealth and M m 27 Is marl		Genesis Wentworth 1801	g Address (Street and Number or Rural Route N WEntworth Avenue Balt	imore, MD	21234
Baltimore,	permit. Pages 1 an Department of Heal Important: If item 2 any injury or other once.		'4 □ Donation 5 ☑ Other (Specify) in state	natory or other place)	20c. Location - Cit	,
Ba	permil Depar Impor any ir		Jenul // Juli Ba.	Name and Address of Facility ate Anatomy Board 655 ltimore, MD 21201		
ì	Physician /Medical		23a. Part 1 Enter the disease or complications that caused the death. Do not ente shock or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)			Approximate Interval Between Onset and Death
	Examiner	er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying  Due to (or as a consequence of):  Due to (or as a consequence of):	yourder and.	1 resul	year
8760,	death certificate be executed e attending physician and ad for use as the burial-transit	dical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):			
9	ertificate ing phy: e as the	Medic	IF FEMALE:			
P.O. Box	that the death certified by the attending of detached for use as	by Physician/Me	23b. Was decedent pregnant in the past 12 months?	Ectopic pregnancy Other (specify)	23d. Date o Month	f delivery Day Year
	The law requires that the ste has been signed by the bage 2 should be detache	ted by PI	Part II. Other significant conditions contributing to death but not resulting in the unit			te to the cause of death?  Probably 4. Unknown
of Vital Records,		Completed			autopsy performed? dea:	e autopsy findings available r to completion of cause of th? Yes 2 \(\sum \text{No}\)
Zit.	Physician: Th this certificate ral director, pag	To Be	25. Was case referred to dical examiner?  1 Yes 2 10 Hospital: 1 Inpatient 2 ER/Outpatient	26. Place of Doeth (Check of 3 DOA) Other: 4 Nursing Home 5 1		(Specify)
ion of	ng ftel		27. Mann   f Death   28a. Date of Injury (Month, Day Year)   28b. Time of Injury (Mont		ribe how injury occurred	Эрвспуу
Division	tal or Attendi s after death. al Director: A ed in by the fu	Certification;	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, stre building, etc. (Specify)	et, factory, office 28f. Locati City o	on (Street and Number or r Town, State)	or Rural Route Number,
	To the Hospital or At within 24 hours after d To the Funeral Direct completely filled in by	edical	29a. Certifier (Check only one)  1 Continying Physician. To the best of my knowledge, deam 2 Medical Examiner: On the basis of examination and/or investigation and manner stated.	estigation, in my opinion, death occurred at the ti	ime, date and place, and	due to the cause(s)
)	To To Com	Σ	29b. Signature and title of certifier  The property of the control	29c. License number  DOUSSSS	29d. Date signed (A	Month, Day, Year) 14 8 2006
			3. Name and address of person who completed cause of death (Item 23a) (Type, P  PATP "  31. Date filed (Month, Day, Year)  32. Registrar's Signature	Print) 8903 HA	ARYCH	Ro10
	Sta Registr		MAR 1 4 2006 See A Special Street			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend item 26 per doc 9853 3-14-06 vt.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. UU b 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician Year Month Connie Lea Paylor 3 2006 9:00 p /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 1401 N. Lakewood Avenue Apt 310 Balto N/A 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, Year) 9. Birthplace (State or Foreign Country) N.C. 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours 1□M 2√ F 241-46-3062 **Director** 78 11-30-1927 Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show traumatic avant, the Medical Exerciner roust by notified at 1 Yes 2 No Director Md N/ABalto 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death w. Department of Heatth and Mental Hygiene. Important: if itam 27 is marked othar than "natural", or Itams 23a any injury or othar traumatic avant 1401 N. Lakewood Avenue Apt 310 21213 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 22☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No δ Specify: Black 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Geriatric Aide Elementary/Secondary (0-12) College (1-4or 5+) N/A 9th grade Nursing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Hubert Winstead Ida Wade ೭ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda Rhinehart - Daughter 8508 Winands Road Pikesville, Md 21208 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Metro Crematory 3-9-2006 Catonsville, Md \* 4 □ Donation 5 □ Other (Specify) 21. lign sure of Funeral Service Lucensee 22. Name and Address of Facility March F/H West 4300 Wabash Avenue Balto, Md 21215 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician ardiovas /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Little onceing a Cause (Disease or injury Due to (or as a consequence of) Examiner Cardiomy pathy The law requires that the death certificate be executed the burial-transit that initiated events resulting in death) Last and Due to (or as a consequence of). Division of Vital Records, P.O. Box 68760. attending physician Physician/Medical use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy for Month Day Year 4 Pregnant at time of death 5 Other (specify) signed by the at id be detached fo 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Tes 2 No 3 Probably 4 Munknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No a 24a. Was an has page 2 autopsy performed? Yes 2 10 No certilicate 1 Yes To the Hospital or Attanding Physician: Be 25. Was case referred to medical examiner? 26. Place of Death Check on one Hospital: 1 ☐ Inpatient 2 ☐ Envoutpatient Other: 4 Nursing Home Residence 6 Other (Specify) ို 1 Tes 2 No 3 DOA this naral Diractor: After the filled in by the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 🔲 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after To the Funeral Dire 4 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6 Orleans Jt Baltimore 31. Date filed (Month, Day, Year) 32. Registrar's Signature

State
 Registrar

			State Registrar	ite of Maryland	-	artment of He tificate of D		nd Me		iene eg. No.	)	07664
	Physicia /Medic		Decedent's Name (First, Middle, Last)     LOUSE HOWARD PARK	KER					2. Date of Deal Month 03.07.	Day	Year	3. Time of Death
	Examin		4a. Facility Name (If not institution, give street a	·		4b. City, Town, or I	Location of	Death			ounty of Death	_
			MANOR CARE NURSING  5. Social Security Number  6. Sex	7. Age (In yrs. las	t hirthday)	TOWSON If Under 1 Year	If Under 2	4 Hrs.	3. Date of Birth		LTIMOR	
	Funeral Director		215 · 32 · 2180   1   M 2		Yrs.	Months Days	Hours	Min.	(Month, Day, 05 12 ·	1916	Cot	nplace (State or Foreign untry) MD
	72 hours after death with the Maryland naturel', or Items 23a or 28a-f show dical Examiner must be notified at		10a. State 10b. County	10c. City,	Town or Lo	cation						10d. Inside City Limits
	a-fst	ctor	MD NA	BALTII	MORE							1 🔂 Yes 2 □ No
	or 28	Funeral Director	10e. Street and Number	~		10f. Zip Code			1	0g. Citize	on of What Cou	untry?
	s 23a	sral	3038 BRIGHTON STREE		10.3	21216	nonio Orio	in? (Spoo	ify Voc or No-	14	USA Race - Amer	ican Indian
	tter de	-une	An	as Decedent Ever in U.S. ned Forces? ]Yes 2 <b>6</b> 2No		Was Decedent of His f Yes, specify Cubar	n, Mexican,	Puerto R	ican, etc.)		Black, White	e, etc.
980	al', o	by	_ If Y	es, Give ar or Dates:		1 ☐ Yes 2 🛣 No	Specify:			S	Pecify: BLA	K
21215-0036	72 ho	Completed	15. Decedent's Education (Specify only highest grade comp		16a. Deced	dent's Usual Occupa kind of work done di DO NOT use retired)	tion uring most	of working	9		of Business/I	
121	within lene. than "	Idm	Elementary/Secondary (0-12) Co	llege (1-4or 5+)		DO NOT use retired) 1E MAKEI				D	OMESTI	c.
5	e filed v al Hygie other t vent, IL		12. 17. Father's Name (First, Middle, Last)	NA	HON			's Name	First, Middle, I			
Maryland		To Be	LLOYD GANHER						JARDS		ŕ	
ary	2 should and Men is marke aumatic	1	19a. Informant's Name/Relationship (Type, Pri	int)	19b. Mailir	ng Address (Street a				, City or 7	Town, State, Z	ip Code)
Š	1 and 2 Health a em 27 is		ROBERT GAMHER (BRO	MUER)	5024	GREENSE	BRIDGE	E RO	. DAYT	NO		
altimore,	of He of He fitem		20a. Method of Disposition 1   Burial 2 □ Cremation 3 □ Remova	st from State cen	netery, crer	sition (Name of natory or other place	· 1	Da			ation - City or 1	
Ĕ	Pages ment of l ant: If its jury or o		`4 □ Donation 5 □ Other (Specify)	BALT		i cemeter			1.06 1	3AUTI	MORE,	MD
Ball	permit. Pages Department of Important: If i any Injury or once		21. Signature of Funeral Service Licensee	_	VA	Name and Address UGHN C. GR ELBAUTO NA	EENE	PUNE	ERAL SEA	ZIZZ	}	
			23a. Part1. Erter the disease, or complication shock, or heart failure. List only one cau	s that caused the death. se on each line.								Approximate Interval Between
	Pnysician		Immediate Cause (Final disease or condition	CARCI.	NO.	MA	0)	20	116			Onset and Death  I Clary.
	/Medical Examiner		resulting in death)	Oue to (or as a conseque	nce of):	(	2					/
		ē	Sequentially list conditions, b	Due to (or as a cons ≠ ue	nce of							
J	uted I Insit		Cause. Enter Underlying Cause (Disease or injury									
ď	be executed Ician and burial-transit	Exam	that initiated events c. resulting in death) Last	Due to (or as a conseque	nce of):							
8760	ate be ex hysician the buria	edical	d								-	
9	ntifica ing ph e as th	Med	IF FEMALE:									
Вох	death certific e attending p id for use as i	lan/I	23b. Was decedent pregnant in the past 12 months?	res, outcome of pregnanc ☐Live birth 2☐ Fetal d	eath 3	Ectopic pregnancy				23	d. Date of deli Month	very Day Year
0	the de	Physician/M	1 \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	□Pregnant at time of dea □Unknown	th 5L	Other (specify)						·
σ.	that the de led by the detached		Part II. Other significant conditions contributi	ng to death but not result	ing in the u	nderlying cause give	n in Part I.		23e. Did to	pacco use	e contribute to	the cause of death?
ds,	es gr	d by							1 🗆 Yo	es 2 🗆	No 3 ☐ Pro	obably 4 Unknown
of Vital Records,	> 0 0	ompleted							24a. Was a	n	24b. Were au	topsy findings available
Re	9 4 9							_	autops perfori 1 Yes		prior to death?	completion of cause of 2 \sum No
ital		Bec	25. Was case referred to medical				26. Place	of Death	(Check only or	/ N		
f V	ys d	ToE	examiner? 1 ☐ Yes 2 No Hospita	1 Inpatient 2 E	R/Outpatier		4 Vur	sing Hom	e 5 ☐ Reside	ence 6	Other (Spec	city)
n C		on:	1 XNatural 5 ☐ Pending	a. Date of Injury 2 (Month, Day Year)	8b. Time of Injury	Work	:?		3d. Describe h	ow injury	occurred	
sio	ten leal tor: the	icat	2 Accident investigation 3 Suicide 6 Could not be	. Place of Injury - At hom	e form et		/es 2□N	_	Rf Location (S	reet and	Number or Ru	ıral Route Number,
Division	in Dir	ertification:	4 Homicide determined 206	building, etc. (Specily)	10, 14mm, 3tt	eet, lactory, onlos			City or Town	n, State)		
	To the Hospital within 24 hours of To the Funeral I completely filled	edical C		To the best of my knowled the basis of examination of manner stated.	edge, deat n and/or in	h occurred at the tim vestigation, in my op	e, date and pinion, deat	l place, ar	nd due to the c d at the time, d	ause(s) a ate and p	nd manner as place, and due	stated. to the cause(s)
	To the Hos within 24 h To the Fun completely	Mec	29b. Signature and the of certifier	id manner stated.		29c. License			2	9d. Date	signed (Month	n, Day, Year)
	with To		V/1/1/00/16	adi'm		2-0	2010	284	19	3-,	8-0%	
7	10		30. Name and address of person who complete	ed cause of death (Item 2	23a) (Type.	Print)		2			7 9	D 21204
	10		AH. GHILADI.	32 Registrar's Signatu	600	0 056	ER	B	100	150.	NI	1) 21204
	. Sta		31. Date filed (Month Day, Year) 2005	32 Registrar's Signatu	te e	ast s						
	Registi	ar	MIN T 2 F000	Field Store Start	September 1	-0,00						

			1 - State of Maryland /	-	artment of H			giene Reg. No.	6	0766	5
ĺ	Physici		Decedent's Name (First, Middle, Last)     JEAN ELIZABETH PARKER				2. Date of Dea Month 03	10 Day 2006	Year	3. Time of D 3:00A	Death M
	/Medic Examin		4a. Facility Name (If not institution, give street and number)  LEVINDALE NURSING HOME			Location of Death	J	4c. County	of Death		•
	Funeral Director		5. Social Security Number 6. Sex 1 ☐ M 2 ☒ F 7. Age (In yrs. last 1 ☐ M 2 ☒ F 73  Usual Residence of Decedent	birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day	/, Year)	9. Birth	place (State or ntry) VA	
	Maryland I-f show	tor	10a. State 10b. County 10c. City, To	own or Lo						10d. Inside City	
	ith the	Director	10e. Street and Number		10f. Zip Code			10g. Citizen of W	hat Cou	ntry?	
	s 23e	erai	2515 BOSTON STREET  11 Marital Status  12. Was Decedent Ever in U.S.	40.1		21224	anife Veneralla	USA	A	can Indian,	
22	urs after d al', or Itam Evandine	by Funerai	11. Marital Status  1 Never Married 2 Married  3 Vidowed 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 Yes 2 No If Yes, Give Year or Dates:		Was Decedent of H f Yes, specify Cuba 1 ☐ Yes 2☐ No	Specify:	Rican, etc.)		k, White,	etc.	
0-0-12-1	be filed within 72 hours after death with the Maryland Hygiene. do other than "netural", or Itams 23e or 28e-f show avent, the Medical Examinating to indiffed at	Completed	(Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)	(Give	dent's Usual Occup kind of work done o DO NOT use retired CLERK	during most of work		16b. Kind of Bu	siness/In	ndustry	
7	filed v Hygie sthartl		12 17. Father's Name (First, Middle, Last)		CLERK	18. Mother's Nam		N.Y. DE		OC. SERV	/ ICE
) y lail	s 1 and 2 should be filed within I Health and Mental Hygiene. Item 27 Is marked other than other traumatic avant, tha M	To Be	JOHN WALTON  19a. Informant's Name/Relationship (Type, Print)  1	9b. Mailir	ng Address (Street		LIZABETH			2 Code)	
M	od 2 c				BOSTON S			•		,	
20	Pages 1 ar nent of Hea int: If itam 3 iry or other		20a. Method of Disposition  20b. Place come 157 Burist 2 Compation 3 Removal from State	of Dispo	sition (Name of natory or other place CEMETERY	9)	Date	20c. Location - (	City or To		NY
Dall	permit. Pages: Department of I- Important: If its any injury or ot		21. Signature of Funeral Service Licensee		2. Name and Address 1701 LAUR	ENS STRE	MES A. M ET., BAL	TIMORE.	SON MD	S F.H., 21217	INC
100	nysician /Medical	E IV	resulting in death)	o not ent	FAILURE	g, such as cardiac	or respiratory ari	rest,		Approximate Interval Between Onset and De	een eath
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· ·	be executed ician and burial-transit	Examiner	Sequentially list conditions, that y, leading to first ediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence or injury that initiated events)		disease					yew	5
00/00	ificate be g physicia as the bur	dicai	d. Drubetes M	el(i+	US					year	. 2
.0.	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 brours after death.  On the Funaral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the buriat-transit.	hysician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown  23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal dea 4 □ Pregnant at time of death		Ectopic pregnancy Other (specify)			23d. Date Mon		,	ear
ords, r	w requires that been signed b should be deta	by P	Part II. Other significant conditions contributing to death but not resulting per pherod VESCULAR desuge with who					obacco use contri 'es 2□No	bute to t 3 ☐ Prot	/	
200	The law requate has been bage 2 should	ompieted	PRESPIRATORY FAILURE SECONDARY to MI			dependent	perfor	sy p	rior to co eath?	opsy findings averaged for the completion of cau	vailable use of
120	cian: ertifica ector,	Be C	25. Was case referred to medical examiner?			26. Place of Deal	h (Check only or	ne)			
	*Attending Physician: The lav ar death. factor: After this certificate has by the funeral director, page 2	tion: To	1 Yes 2 No Hospital: 1 Inpatient 2 ER/  27. Manner of Death 1 Natural 5 Pending 2 Accident investigation (Month, Day Year)	Outpatien  Time of Injury	28c. Injun Wor	4 W Nursing Fig	ome 5 Resid	ence 6 Othe		(y)	
	To the Hospital or Attending F within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Sertification:	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, building, etc. (Specify)	farm, str	eet, factory, office		28f. Location (S City or Tow	treet and Numbern, State)	or Run	al Route Numbe	er,
	To the Mospitel or within 24 hours afte To the Funeral Dir completely filled in	edical C	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowled and manner stated.	dge, death and/or inv	occurred at the tin vestigation, in my o	ne, date and place, pinion, death occur	and due to the cred at the time, c	cause(s) and mar date and place, a	nner as s nd due t	stated. o the cause(s)	
	To the within To the comp	Ž	29b. Signature and title of certifier		29c. License		2	29d. Date signed		Day, Year)	
	1		1/2m			3:377		3/12/0			
	V	-0:	30. Name and address of person who completed cause of death (Item 23: Debot W. (Cop & WW) 673 NAC.  31. Date filed (Month, Day, Year)  MAR 1 4 2006	a) (Type, LH	Print) EIGHTS	AVERIUE	MACT	IMORE I	NI	2121	5
	Sta Registr		31. Date filed (Month, Day, Year)  MAR 1 4 2006  MAR 1 4 2006	Sin	Single Control						

JEAN PARKED

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 1nda 14:09 M maren 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Bayview Medical center | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 05-08-1949 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2 1 F 213-52-2208 56 Director Massachussetts Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Illimportant: If Itam 27 is marked other then "natural", or itema 23a or 28a-1 show any injury or other traumatic event, the Medical Examinar must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes XXNo Director Maryland Baltimore Dundalk 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7405 St. Patricia Court 21222 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give A Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No White Specify: Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Assembler Automobile 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Herbert L. Casewell Naomi Ruth 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael Piper / Husband 7405 St. Patricia Court, Balto. MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 03/13/2006 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) Metro Cremetory 22. Name and Address of Facility Charles S. Zeiler & Son, Inc. 21. Signature of Furreral Service License 6224 Eastern Ave., Baltimore, MD 21224 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Sepsis

Due to (or as a consequence of): /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed Due to (or as a consequence of): attending physicien a for use as the burial-Division of Vital Records, P.O. Box 68760, Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day 4☐ Pregnant at time of death 5 Other (specify) ed by the a detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ ste has been signi page 2 should be 2 No 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No this certificate 2□ No 1 ☐ Yes 1 Yes Be director 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: ٩ 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No 2 Accident investigation Director: 3 Suicide 6 Could not be determined Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours after 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) To the 29d. Date signed (Month, Day, Year) March, 09, 2006 29b. Signature and title of certifier 29c. License number RES-000 09 M. D. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Anne Graves Tuskey 4940 Eastern Ave. Baltimore, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAR 1 4 2006 Registrar

06-1654 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Unpend item#23a, PII 27, perME 8853 3/27/06 TT State of Maryland Department of Health and Mental Hygiene B.K.S ANITA PEREZ For State Registrar 1-Certificate of Death Reg. No.-2. Date of Death Month Day **Physician** MARCH 2006 1102 /Medical 4c. County of Death acility Name (If not institution, give street and number) NORTHWEST HOSPITAL 4b. City, Town, or Location of Death Examiner RANDALLSTOWN BALTIMORE 7. Age (In yrs. last birthday)
Yrs. If Under 1 Year | If Under 24 Hrs. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** -84-8388 Days 1 □ M 2 💢 F Director Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examinar must be notified at Yes 2 □ No Funeral Director 10e. Street and Number 10g. Citizen of What Country? Of, Zip Code Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 XNo Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working ife. DO NOT use retired) 15. Decedent's Education fy only highest grade completed) 16b. Kind of Business/Industry other than dary (0-12) College (1-4or 5+) asmeto Pages 1 and 2 should be filed w thent of Health and Mental Hygie tant: if Item 27 is marked other t jury or other traumatic event, in 17. Father's Name (First, Middle, Be ဥ 19b. Mailing Address (Street and Nur Department of Health Important: if Item 27 any Injury or other troops. Disposition Burial 2 □ Cremation 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying shock, or heart failure. List only one cause on each line. interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Cardiac arrhythmia /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed attending physicien and for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐ Pregnant at time of death 5 ☐ Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Seizure Disorder, Diabetes mellitus, human immunodeficiency 2 🗆 No 3 Probably 4 Dunknown been sign viral infection 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☑ Yes 2□ No certificate has tirector, page 2 s autopsy performed? 2 No 1 Yes To the Hospitel or Attending Physician: : After this certification : 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 XYes 2 □ No 2X ER/Outpatient 3 DOA 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funerel Director: completely filled in by the 3 🗌 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State

DHMH 17 Rev 1/2001

Registrar

31. Date filed (Month, Day, Year)

32. Rg

200\$

O.C.M.E

death (Item 23a) (Type, Print) 111 PENN STREET, BALTIMORE, MARYLAND 21201

MARCH

8, 2006

		-		partment of Health and Mental Hyg ertificate of Death	iene 95 No. 0 1 0 7 6 6 8
F. 3	Physicia	100	1. Decedent's Name <i>(First, Middle, Last)</i> David E. Queen Sr.	2. Date of Dea Month Februar	Day Year
1	/Medic Examin		4a. Facility Name (If not institution, give street and number) Bowie Health Center	4b. City, Town, or Location of Death Bowie	4c. County of Death Prince George's
	Funeral Director		5. Social Security Number 217-38-4018 6. Sex 1 M 2 F 65 Yrs.	y) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day May 28	(, Year) Country)
	Maryland f show	o l	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Maryland Anne Arundel Gambri		10d. Inside City Limits 1 ☐ Yes 2 No
	th the h or 28a-	Funeral Director	10e. Street and Number		log. Citizen of What Country?
	sath wi	erai C	2401 Queen Mitchell Rd.	21054  3. Was Decedent of Hispanic Origin? (Specify Yes or No-	USA  14. Race - American Indian,
396	s 1 and 2 should be filed within 72 hours after death with the Maryland I Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23s or 28s-f show other traumatic event, the Marical Examinar must be indiffed at	þ	11. Marital Status  1 Never Married WMarried  3 Widowed 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 Yes 2 No II Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)     □ Yes XXNo Specify:	Black, White, etc.  Specify:Black
15-0	nin 72 hou n "natura	Completed	(Specify only highest grade completed) (Gi	cedent's Usual Occupation ve kind of work done during most of working . DO NOT use retired)	16b. Kind of Business/Industry
212	e filed with Il Hygiene other the	Com	12th 4yrs	Manager  18. Mother's Name (First, Middle,	Nevamar
land	id be fil lental H ked oth ic even	То Ве	17. Father's Name (First, Middle, Last)  Lewis Queen	Anna Turner	Malouri Surramey
Maryland 21215-0036	1 and 2 should Health and Mi Iem 27 is mari othar traumati	-		uling Address (Street and Number or Rural Route Numbe 1 Queen Mitchell Rd Ga	
Baltimore,	Pages 1 a nent of Heis int; If item iry or otha			position (Name of Date General Park 3-6-06	20c. Location - City or Town, State Annapolis, Md.
Balti	permit. Pages i Department of H Important; if ite any injury or ot once.			22 Name and Address of Facility Wm. Reese & Sons Mortu 821 West St. Annapolis	
	Physician		23a. Part 1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition	enter the mode of dying, such as cardiac or respiratory are	rest, Approximate Interval Between Onset and Depth
	/Medical Examiner		resulting in death)  Due to (or as a consequence of):	En las	lus
	ted nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	10000000	
, 09/	te be executed ysician and ne burial-transit	icai Exar	that initiated events resulting in death) Last C. Due to (or as a consequence of):		
9			IF FEMALE: 23c. If yes, outcome of pregnancy		23d. Date of delivery
.O. Box	0 0	Physician/Med		3 Ectopic pregnancy 5 Other (specify)	Month Day Year
0_	as the	by	Part II. Other significant conditions contributing to death but not resulting in the	e underlying cause given in Part I. 23e. Did to	obacco use contribute to the cause of death?  Yes 2 No 3 Probably 4 Unknown
Records,	The law require rate has been signage 2 should b	Completed	Rheumatic Meart	24a. Was autor perfo	
Vital	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	26. Place of Death (Check only of Check on C	ne)
of	ing Phys Viter this uneral di	on: To	27 Manner of Death  Lavatural 5 Pending  28a. Date of Injury (Month, Day Year)  Injury	e of Work? 28d. Describe I	dence 6 Cother (Specify) Would's Cother (Speci
Division	l or Attending after death. Director: After I in by the fune	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm building, etc. (Specify)	M 1 Yes 2 No  street, factory, office 28f. Location (3 City or To)	Street and Number or Rural Route Number, vn, State)
	To the Hospital or Attentwithin 24 hours after death To the Funeral Director:	Medical Ce	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, d and manner stated.	eath occurred at the time, date and place, and due to the r investigation, in my opinion, death occurred at the time,	cause(s) and manner as stated. date and place, and due to the cause(s)
	To the within To the comple	Me	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
	4		30. Name and address of person who completed cause of death (Item 23a) (Ty	po, Print)  H im Ala ha Alio il	10 21401
*		ate	31. Date filed (Month, Day, Year) 32. Registrar's Signature	1100130000	
4	Regist	rar	MAR 1 4 2006	14.52.3	

			1 - For Stata Ragistrar	State of N	Marylan			of Health a		_	giene Reg. Nő.	UUb	07669
	Physic		1. Decedent's Name (First, Middle, L Herman H. Runyen S							2. Date of De Month March	ath Day		3. Time of Death 4:00p M
	/Medi Examir		A. C. The New Miles of the Control o								County of Death		
3.9	Covil	182	Montgomery General  5. Social Security Number 6.	Sex 7.7	Ane (In vrs	last birthday)	01 n		24 Hrs	9 Date of Bird	M	ontgomery	alana (Chaha an Farria
	Funeral Director		217-03-2515	1 <b>∑</b> M 2□F	90	Yrs.		Days Hours	Min.	8. Date of Bird (Month, Da March 1		Cou	* *
0	land ow		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location										10d. Inside City Limits
	Mary Fied s	tor	Maryland Montgom	ery	Si	ilver Sp	ring						1 X Yes 2 □ No
	th the	Director	10e. Street and Number		1		10f. Zip C	ode			10g. Citi:	zen of What Cou	ntry?
C Z I Z I 3-0036 filed within 22 hours after death with the Manyland	ath wi	ral	15009 Peachstone Dri				2090	20905 Uni				d State Am	nerica
	be filed within 72 hours atter death with the Marylan ital Hygiene. d other than "natural", or items 23s or 28s-f show event, the Medical Examiner must be redified at	by Funeral	11. Marital Status  1 Never Married 2 Married  3 X Widowed 4 Divorced	12. Was Deceder Armed Force: 1 Yes 2 [ If Yes, Give Year or Dates	rces? If Yes, specify Cuban, Mexican, Puèrto Rica 2 □ No 'e 1945 = 1 □ Yes 2 ⊠ No Specify:				cify Yes or No Rican, etc.)	ry Yes or No- can, etc.) 14. Hace - A Black, W Specify:		can Indian, etc. ni te	
	hin 72 ho s. In "natur Medical	Completed	15. Decedent's (Specify only highest g			16a. Deced	sedent's Usual Occupation re kind of work done during most of working . DO NOT use retired)			16b. Kir	16b. Kind of Business/Industry		
7	filed with Hygiene other the	Com	12 Bus Operator								City		
Maryland 2	B is b	Be	17. Father's Name (First, Middle, Las	st)				18. Mothe	er's Name	(First, Middle,	Maiden	Sumame)	
ry is	2 should be a and Mental I is marked o	L <sub>O</sub>	Robert Runyen  19a. Informant's Name/Relationship	(Type Print)		10h Mailio	a Addrson /6		(ilgore			T C4-4- 7	- C- (-)
	s 1 and 2 should f Health and Mer Item 27 is marke other traumatic		Virginia Riley/Daugl									r Town, State, Zip ryland 20	
salumore,	m O		20a. Method of Disposition		20b. P	lace of Dispo	sition (Name	of er place)		ate	77.	cation · City or To	
Ĕ	Pages ment of ant: If It		1 🎾 Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spec			ion Ceme		- 1	lar. 16	5, 2006 E	Burtor	nsville, M	aryland
	permit. Page Department Important: If any Injury or once.		21. Signature of Funeral Service Lice	ensee	-	F	Teck Fu	Address of Facili neral Homo	é	30			
	40244		23a, Part 1, Enter the disease or con	nolications that caus	ed the death	760	01 Sandy	/ Spring R	Road, L	aurel, N	laryla	and 20707	Approximate
	Physician /Medical		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Atherosclerotic Disease  Due to (or as a consequence of):									Interval Between Onset and Death Years	
	Examiner												
*	D #3	Iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying										
'n	cate be executed oblysicien and the burial-transit	i Examin	Cause (Disease or injury that initiated events c										
00/00	physic physic the b	dlcai	•	d									
O. DOX	requires that the death certifics een signed by the attending pr nould be detached tor use as t	ysician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes   2   No   9   Unknown   9   Un								2	23d. Date of delivery Month Day Year	
	that the phase of detact	y Physi	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tob							obacco u:	pacco use contribute to the cause of death?		
ה ה	w requires that the de been signed by the should be detached	ed by								101	∕es 2∑	QNo 3□Prob	pably 4 \understand Unknown
vital necolus,	> 4	Completed								24a. Was autop		24b. Were auto	opsy findings available impletion of cause of
2	en: T tificat tor, pa	0	25. Was case referred to medical					26 Place	of Death	1 Yes	2 X No	1 🗆 Yes	2 No
>	hysicl nis cer I direc	To B	examiner? 1 □ Yes 2 ☑ No	Hospital: 1X Inpa	tient 2 1	ER/Outpatient	26. Place of Death (Check onleant 3 DOA Other: 4 Nursing Home 5 Re				Residence 6 Other (Specify)		
5	ing Pt		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of In (Month, D	jury Day Year)	28b. Time of Injury		Injury at Work?		8d. Describe h	how injury occurred		
VISION or Attending	or Attend after death Director: / in by the f	Certification:	2 Accident investigation M 1 Yes 2 No							Street and vn, State)	et and Number or Rural Route Number, State)		
	To the Hospitel or Attending Physicien: The law within 24 burus after death.  § to the Funeral Director: Satte this certificate has pempletely tilled in by the funeral director, page 2	edical Ce	29a. Certifier 1 Certifying P (Check only 2 Medical Exa	hysician: To the bes	of examinat	wledge, death ion and/or inv	occurred at restigation, in	the time, date an my opinion, dea	nd place, as	nd due to the o	cause(s) date and	and manner as s place, and due to	tated. o the cause(s)
	within compl	Me	29b. Signature and title of certifier				29c. L	icense number			29d. Date	e signed (Month,	Day, Year)
	Par		All Affect	Physic		02-) 7		55694		1	March	13, 2006	
			30. Name and address of person who Alok Mathur 4000	Olney-Lcyto				Marvland	2022				
	Sta		31. Date filed (Month, Day, Year)	32. Regis	trar's Signat	ture	orney, i	naryranu Z	.0032			-	
	Registr	rar	MAP 1 4 2	nne		de And	0 a M. D						

Amend item#30, perfVR, QS53, 3/14/06 TT State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death **Physician** Joan L. Rupp /Medical Examiner vrs. last birthday) 8. Date of Birth **Funeral** (State or Foreign Days 216-40-0021 1 ☐ M 2 👽 F Months 61 Maryland Director Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at MD Baltimore White Marsh Director 1 ☐ Yes 2 No 28a-1 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 5853 Loreley Beach Road 21162 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. I ∏Yes 3√∏No If Yes, Give Year or Dates: 1 Never Married 2 Married ŏ 1 ☐ Yes 2 No Specify: þ Specify:White 3 Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry illed within Old Castoe APG other then Elementary/Secondary (0-12) College (1-4or 5+) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. Office Manager 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Leo H. Moran Anna Wagner Mary 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health Sheri Rupp /daughter 5853 Loreley Beach Road White MArsh othert Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other 20a. Method of Disposition Date 20c. Location - City or Town, State ō <u>=</u> 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Important: if eny injury or gode. DulaneyValley 3/17/06 Baltimore MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility ConnellyFuneralHomeofEssex 21. Signature of Funeral Service Licenses 300 Mace Ave. Baltimore MD 21221 23a. Part1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on such in a not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner ed by the ettending physicien end deteched for use as the burial-transit certificate be executed resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown 3 Ectopic pregnancy 4☐Pregnant at time of death Month Day Year P.0. 5 Other (specify) 9 Unknown been signed by should be detect Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ۾ 23e. Did tobacco use contribute to the cause of death? Records, Completed 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 22 No certificate Division of Vital 1 ☐ Yes : After this certifice funeral director, i Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death Check only one Hospital: npatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes ٩ 220No 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred Natural 5 Pending investigation Injury ours efter death. nerel Director: All filled in by the fur 2 Accident 1 Tes 2 No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after To the Funerel Dire 4 Homicide Hospital or Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature,and (itle of certifier 29c. License number 29d. Date signed (Month, Day, Year) 6133 My 4 3/12/06 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kirmanj Ahmed Baltimore Md 9000Franklin S 32. misstrar's Signativare 21236 Drive 31. Date filed (Month, Day, Year) State 4 Registrar

State Registrar DHMH 17 Rev 1/2001 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MAR 1 4 2006

31. Date filed (Month, Day, Year)

OCME

111 Penn Street

March 13, 2006

Baltimore, Maryland 21201

				State of M	laryland		rtment of		d Mental Hy	giene Reg. No.	16	07672	
			1. Decedent's Name (First, Middle, Last	)					2. Date of De	ath	Vaar	3. Time of Death	
	Physici /Medic			Eleanor	Robei	rts			March	Bay 2	Yeer	12:30 AM	
	Examin		4e. Fecility Name (If not institution, give	street and number	7)			4b. City, Town,	or Location of Deet	4c. Cour	nty of Deeth	1	
			Roland Park Place	12.			Hillada d Mara	Baltim				/A	
	Funeral Director		436-20-0190	x 7. A	ge (In yrs. la	35 Yrs.	Months Days		lin. 8. Date of Bir (Month, De Dec. 23	th by, Year) , 1920	9. Birth Cou Io	nplace (State or Foreign untry) Wa	
the Maryland	and w		Usual Residence of Decedent  10e. State 10b. County		10c. City.	Town or Loc	ation					10d. Inside City Limits	
	Manyli f aho	5		/A	100.0,	_	Baltimor	e				X1X1Yes 2□No	
	28a-	rect		7			10f. Zip Code			10g. Citizen o	of What Cou	untry?	
	3e ol	Funeral Directo	Roland Park Place 830 W. 40th Street					21211			U	SA	
	deeth	ner		12. Was Deceden Armed Forces	t Ever in U,S	. 13. W	/as Decedent of	Hispanic Origin?	(Specify Yes or No erto Rican, etc.)	- 14. R		ican Indian,	
070	permit. Pegas 1 and 2 should be filed within 72 hours aftar deeth with the Maryland Deperfurnant of Haatily and Martial Hyglene. Deperfurnant of Haatily and Martial Hyglene. Introorbant: If tiern 27 is marked other then "naturel" or items 23e or 28e-f ahow eny injury or other traumatic event, the Medical Examiner must be notified at once.	by Fu	1 ☐ Never Married 2 ☐ Married  3 🛣 Widowed 4 ☐ Divorced	1 ☐ Yes 2 🔯 If Yes, Give Yeer or Dates:	※0		☐ Yes 2KDNo		erto nicari, etc.)	Spec	lack, White	white	
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2	be fill d off	Be	17. Father's Name (First, Middle, Last) Lloyd Croutch					18. Mother's N	Name <i>(First, Middle,</i> Reyno1d		eme)		
2	hould d Mar marke	င္	19a. Informant's Name/Relationship (Ty	ma Print		10h Mailin	Addrson /Ctros		Rural Route Numb		m Ctata 7	in Code)	
N N	d 2 s th an 17 is r trau		Hugh C. Roberts	Son			oylan Av		Media, Pe			19063	
<u>נ</u>	Haa Haa tam 2		20a. Method of Disposition	5011	20b. Pla	ce of Dispos	ition (Neme of		Date	20c. Location			
nit Pagas	ant of ant of art: If i		1 ☐ Burial 2 XX remation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	temoval from State	9		atory`or other pla ematory	ice)	3/10/06	Cator	nsvil	le, MD	
	mit. I sortar ninfu		21. Signature of Funeral Service Licens	ae /		22.	Name and Addr	ess of Facility					
ì	Deg e sign		Janet Ca	puter		Bi	irgee-He 531 Fa11	nss-Seit s Road	tz Funera Baltimor	l Home. e, Mar	, Inc yland	21211	
			23a. PertT. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heert failure. List only one cause on each line.  Approximate Intervel Between Onset and Deat										
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Ŕ	ficata be executed physiclan and is the buriel-transit	Examiner		D		es a consequ		9	1		1	0,0	
Ş	e exe fan ar uriel-t	EX	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause. Enter Underlying Cause (Disease or injury								į		
	cata be executed physiclan and the buriel-transit	dicai	thet initiated events resulting in deeth) Last	)	Due to (or	es e consequ	ence of):						
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;	y the d	Physician/M	Part II. Other significant conditions cor	, 6	but not resul	ting in the un	derlying cause g	ven in Part I.				to the cause of death?	
	that the post of t	by Pt	Nited demention 1□Yes 210No							3 ∐ Pro	obably 4 Unknown		
3	The law requires that the daath certifi ate has been signed by the etlanding page 2 should be detached for usa as								24a. Wes	en autopsy	24b. V	Vere autopsy findings veilable prior to	
	s bee 2 sho	Completed							- pend	med? ' 1	C	ompletion of cause f death?	
	The law ate has page 2	E							10	Yes 2 No	1	□Yes 2□No	
3	ysicien: The la s certificate ha director, page	Be	25. Wes case referred to medical exeminer?					26. Place of D	Death (Check only o	nne)			
	hysic his ce	٥	1 ☐ Yes 2 ☑ No	lospital: 1   Inpet		R/Outpetient	3LI DOA		Home 5 ☐ Resi	dence 6 □0	ther (Spec	ify)	
	Attending Ph or death. ector: After th by the funerel	ö	27. Manner of Death 1 DNatural 5 □ Pending	28e. Date of Inj (Month, Da	ury ay Year)	28b. Time of Injury	28c. Inju		28d. Describe	now injury occi	urred		
2	tend death tor: /	icat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	OOn Place of In	ium. At hom	no form atro		]Yes 2□No	20f Location /	Stroat and Nuc	mbor or Pu	ml Poute Number	
2	al or Al	Certification:	4 Homicide  4 Homicide  4 Homicide  4 Homicide  4 Homicide  4 Homicide  4 Homicide  4 Homicide  4 Homicide  4 Homicide  4 Homicide  4 Homicide  4 Homicide  4 Homicide						City or To	28f. Location (Street and Number or Rurel Route Number, City or Town, State)			
	To the Hospital or Attending Physicien: within 24 hours eller death: 25 the Funarel Director: After this certifical completely filled in by the funerel director.	edical	29a. Certifier (Check only one) 1 S Certifying Phys 2 Medical Examin	siclan: To the best ner: On the basis of end manner s	of examination	ledge, death on end/or inve	occurred at the to estigation, in my	me, date and pla opinion, death oc	ice, end due to the courred at the time,	cause(s) and r date end place	nanner as	stated. to the cause(s)	
	Vithi To #	ž	29b. Signature end title of certifier 29c. License number							29d. Date signed (Month, Day, Year)			
	/		m spahelle Va	agree	gor to	3	013	657	V	March 8,2006			
	5		30. Name and address of person who con PS ABENE Diffe	mpleted cause of	death (Item :	23e) (Type, P	rint)	REETIB	ALTIMOR	E, MD 5	21211		
	Sta Registra		31. Date filed (Month, Day, Year)  MAR 1 4	32. Regis	ak's Signatu	ire	Carles						
			min a T	~~~	Will L. Fillen	JE 19	The same of the sa						

DHMH 16 Rev 6/95

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** 6W BAWOUD ZIAME 27 1ARC 2000 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner UPPERLHESAPEAKE HOSPITAL HARFORD 8. Date of Birth (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days r¶M 2□F Months 74 Director JARYLAND 213-26-6361 1951 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ehow or other treumatic event, the Madical Examiner must be notified as 1 Yes 2 No Funeral Director 1,10027/2001 HARFORD HTORIST H 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or iteme 23a or 402 YHOP 21020 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status TOTAL No If Yes, Give Year or Dates: 1 Never Married 25 Married Specify: WHITE 1 ☐ Yes 2 No þ Specify: 3 Widowed 4 Divorced "naturel" **Be Completed** 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Il Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 765. 127RS OFFICE | ANALYR GETHLEHEM STEE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) . Pages 1 and 2 should be fil Iment of Health and Mental H tent: If item 27 is marked oth WILLIAM I HARLES 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of cometeny, crematory or other place) EVAN FUNCTION ACTION JARTHA L. MIARYLAND AIDSO 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State ortent: If injury o 4 □ Donation 5 □ Other (Specify) JARYLAND 10125 HU 21. Signalure of Fundal Service Licensee Department of the series of th BELL GIR HILL MA PA W. JARYLAND 21050 LNOO 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Death Immediate Cause (Final disease or condition resulting in death) /Medical menic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) a consequence of):

Physician Examiner

death. Director:

Vital Records, P.O. Box 68760,

#10014

filled in by the funeral director, To the Hospital of within 24 hours af To the Funerei D completely filled in

Physician/Medical ģ Be Completed Certification: To

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No

23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death

9 Unknown

3 Ectopic pregnancy 5 Other (specify)

23d. Date of delivery

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

26. Place of Death | Check only one

23e. Did tobacco use contribute to the cause of death? 1 Yes 2 🗆 No

3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy perform 2 No 1 ☐ Yes

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 Tes 27. Manner of eath

2 Accident

3 Suicide

29a. Certifier

Medical

4 Homicide

5 Pending investigation

6 Could not be determined

Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year)

28b. Time of

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. friury at Work? М

1 □ Yes 2 □ No

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

(Check only one) 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

License number

29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 1/2001

15

32 Registrar's Signature

who completed cause of death (Item 23a) (Type, Print)

ORIGINAL

Amend Items 10c, I per Th 8853 3-14-06 VI State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death MARCH 6, 2006 **Physician** RONES 5:00 P MAE /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE JEWISH CONVALESCENT CENTER BALTIMORE 8. Date of Birth JAN. 13, 1920 If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🐼 F 86 Yrs NY 098-16-6488 Director Usual Residence of Decedent the Maryland 10a State 10b Count 10c. City, Town or Location 10d. Inside City Limits 28a-f show other traumatic event, the Medical Examiner must be nutified at Pikesvi11e 1 ☐ Yes 2 🙀 No Director BALTIMORE RANDALLSTOWN MD 21208 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or items 23a or 8416 WINANDS ROAD <del>21133</del> USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐ Yes 2 💢 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify WHITE Specify þ 3 ☑ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) TEACHER **EDUCATION** 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be DAVID SEIDEL JENNY UNKNOWN 0 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 2926 GREENLOW COURT - ELLICOTT CITY, MD 21042 HOWARD RONES / SON 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 □ Burial 2 In Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) HILLTOP SERVICE CORP. 03/10/2006 TOWSON, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** D /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit 00000 and to (or as a consequence of) Box 68760, the attending physicien Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1□Live birth 2□Fetat death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy Po in the past 12 months? Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) Division of Vital Records, P.O. detached 9 Unknown 9 Unknown Š Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a Was an has autopsy 2 No Yes To the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one 1 Yes 2 Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) ∫No 2 filled in by the funeral dir 2 ER/Outpatient 3 DOA this 27. Manner of Death Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending Injury death. 1 ☐ Yes investigation 2 Accident efter death 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Ptace of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide within 24 hours e To the Funeral ( 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifiei Medical and manner stated. 29b. Signature and title of certifier 29d. Dat signed (Month, Day, Year) of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

Registrar's Signature

32.

2006

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend item 20b per in 8853 3-17-06 vt

State of Maryland Department of Health and Mental Hygiene Certificate of Death

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month **Physician** 1,2006 aren /Medical 4c. County of Death 4a. Facility Name (If por institution, give street and number) 4b. City, Town, or Location of Beath Examiner land Baltimore brene 1 8. Date of Birth (Month, Day, If Under 1 Year | II Under 24 Hrs. 9. Birthplace (State or Foreign ial Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min 263-78-950 Usual Residence of Decedent 1 M 2 LF Yrs. Director permit. Pages 1 and 2 should be tiled within 72 hours after deeth with the Maryland Department of Health and Mental Hygiene. Importent: if item 27 is marked other then "naturel", or items 23a or 28a-f ehow eny injury or other treumatic event, the Medical Examination Confided at once. 10b. County 10a. State 10c. City. Town or Location 10d, Inside City Limits Maryland 1 Yes 2 No Director more 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 1823 21 Ne on Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No II Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)  $\alpha$ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 19a. Informant's Name/Relationship (Type, Print) (niece) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3 182 21216 Ruxton okeli Ave salto. Md. 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State cemplate crammony of other place) 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 3-23-2006 4 Donation 5 Dother (Specify) 22. Name and Address of Facility
Joseph L. Russ
2222 W. North re of Funeral Service Censes Home P.A. S. Funeral to 23a. Part l Enter the disease, or complications that caused shock or heart failure. List only one cause on each li Approximate Interval Between Ooset and Death the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Physician days Que to (or as a consequence ol): /Medical Examiner ShOC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine ettending physicien and for use as the burial-transit To the Hospitel or Attending Physician: The law requires that the death certilicate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4☐ Pregnant at time of death 5 Other (specify) is certiticate has been signed by the director, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? β 1 Yes 2 No 3 Probably 4 Onknown Completed 24a. Was an autopsy performed?/ 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Impatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 1 ☐ Yes 2 ☐ ₩o 2 ER/Outpatient 3 DOA this Director: After this 27. Manner of Death 1 Natural 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: Injury 5 🗀 Pending 1 TYes 2 TNo 2 Accident investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours after d To the Funeral Direct completely tilled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certific 29d. Date signed (Month, Day, Year) 30. Name and person ca e of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Bagatrar's Signature State MAR 1 Registrar 4 Mark C

ORIGINAL

			For State Registrar	State of Man		epartmei Certifica			_	giene Reg. No.	6	07678	
	Physici	an	Decedent's Name (First, Middle, Last)     Date of Death     Month     Day								Year	3. Time of Death	
	/Medic		Violet Sterns			larch 8			5:11 AM M				
	Examin	er	4a. Facility Name (If not institution, give					Location of Death		4c. County			
-			Holy Cross Hos  5. Social Security Number 6. S		n yrs. last birth		LVer r 1 Year	Spring If Under 24 Hrs.	8. Date of Birt		Montgomery 9 Birtholece (St		
	Funeral Director			□M 2∏F 67			Days	Hours Min.	(Month, Da	iy, Year) 2, 1938		place (State or Foreign Intry) 'ginia	
			Usual Residence of Decedent						July 12	1750	V 1.1	Бтита	
	arylar show		10a. State 10b. County	10	0c. City, Town	or Location						10d. Inside City Limits	
	8a-f	Director	MD Montgom	ery	Silve	er Spri						1 Yes 2 No	
	with ti	ă	10e. Street and Number 1817 Sanford Roa	3		10f. Zi	p Code	2000		10g. Citizen of V		intry?	
	eeth Film	erai	11. Marital Status	12. Was Decedent Eve	er in U.S.	13 Was Dece	dent of H	2090:		14 Bac	USA	ican Indian,	
220	filed within 72 hours after deeth with the Maryland Hygiene. ther than "naturel", or teme 23a or 28a-f ehow ont, the Medical Exam, or must be coulded at	by Funerai	1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give A Year or Dates:	3 41 0.0.	If Yes, spi	_	Ispanic Origin? (Sp an, Mexican, Puerto Specify:	Rican, etc.)	ì	k, White	, etc.	
	72 ho	ted	15. Decedent's Ed (Specify only highest gra	lucation	16a. I	Decedent's Usi	al Occup	ation during most of work	ina	16b. Kind of Bu	usiness/Ir	ndustry	
717	id within 7 glene. er than "r	Completed	Elementary/Secondary (0-12) College (1-4or 5+) 12 College (1-4or 5+) Secretary									unk	
2	be file tal Hy d oth	Be	17. Father's Name (First, Middle, Last)			·		18. Mother's Nam	e (First, Middle,	, Maiden Suman	ne)		
<u>x</u>	Meni Marke	၉	Lowell Frazier					Lillian					
2	12 sh h and h sr r ts rr rraum		19a. Informant's Name/Relationship (Richard Sterns/	• • • • • • • • • • • • • • • • • • • •		_		and Number or Rur			p Code)		
ב ע	1 and Healti em 2		20a. Method of Disposition					Road Sil	ver Spri	ing, MD  20c. Location -	209		
5	permit. Pages 1 and 2 should be filed within Department of Heath and Mental Hygiene. Important: If item 27 is marked other than eny injury or other traumatic event, the Magnee.		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☒ Donation 5 ☐ Other (Specify)							Ess. Essation	Only Or 1	own, otato	
Da	Departition Depart		21. Signature of Funeral Service Licen Ronald S	Warde Direc	tor	State	Anat	ss of Facility omy Board MD 2120	l 655 W.	Baltim	ore	Street	
ficate be executed physicien and purisitien and surfacturens it is the burial-transit	Physician /Medical Examiner	Examiner	23a. Part1. Ener the disease, if complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or leart failure. List only one cause on each line.  Approximate Interval Between Onset and Death Onset an									Interval Between	
	w requires thet the death certificate be e been signed by the ettending physicien should be detached for use as the burie	Physician/Medical E	d								23d. Date of delivery Month Day Year		
, L	s thet th gned by	by Phy								oid tobacco use contribute to the cause of death?			
	equire en si ould b								10,	Yes 2□No	3 ☐ Pro	bably 4 Unknown	
	rsicion: The law r s certificate hes be lirector, page 2 sh	Completed								psy ormed3	death?	opsy findings available ompletion of cause of 2 1/2/No	
	sicien certif rector	Be	25. Was case referred to medical examiner?	Hospital:	/		Oth	00		h (Check only one)			
5	Phys ral di	7.	1 ☐ Yes 2 ☑ No  27. Manner of Death	1 Inpatient 28a. Date of Injury		patient 3 🗆 🗅	UA	4   Nursing Ho		dence 6 ⊡Oth		ify)	
5	th. After	ţ	27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 2 Accident investigation M 1 1 Yes 2 N.							28d. Describe how injury occurred			
	ii or Attending Physicien: efter death.   Director: After this certifica d in by the funeral director,	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  28f. Location (Street and Number or Rural Route Number, City or Town, State)									ral Route Number,	
	To the Hospital or Attending Physicien: The within 24 hours efter death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	edical C	29a. Certifier 1 Certifying Ph (Check only 2 Medical Exam	ysician: To the best of r niner: On the basis of ex and manner stated	camination and	death occurre	at the tir n, in my o	ne, date and place, pinion, death occur	and due to the red at the time,	cause(s) and ma date and place,	anner as a	stated. to the cause(s)	
	Withir To the Comp	Me	29b. Signature and title of certifier	n		29	c. Licens	e number		29d. Date signe	d (Month,	, Dey, Year)	
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			30. Name and address of person who					2.131		- ~ 1	3	n-UE	
				1 UDZIIW	ND I	500 FE	RES	T GLEN	RD SIL	VER SP	RING	MD 20910	
	Sta Registr		31. Date filed (Month, Day, Year)  MAR 1 4 2006	32. Registrar's	Signature	ach)							

Amend item 5 per inf g854 4-17-06 vt
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend item 18 per fh g853 3-14-06 vt
State of Maryland? Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** nclair-MARCH 12:30 P. M 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** ng (CATER 7. Age (In yrs. last birthday) QL Yrs. If Under 1 Year | If Under 24 Hrs. ville DALTIMURE 5. 218-20-1066 9. Birthplace (State or Foreign Country)
BHLTIMORE MO **Funeral** 6. Sex 8. Date of Birth (Month, Day, Year) 1 M 2 F Months Days Hours Min. Director 21-1912 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits itam 27 is marked other than "natural", or itams 23a or 28a-1 shov other traumatic event, the Modical Examinar over be notified at BALTIMORE To Be Completed by Funeral Director 1 Yes 2 IN Cockeysville 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 21030 3801 USA nex 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry I Hygiene. other than " Elementary/Secondary (0-12) College (1-4or 5+) tomemaker 12 should be filed wind mental Hygien I to marked other th 18. Mother's Name (First, Middle, Maiden Surname)

A Jesse Loeffler 17. Father's Name (First, Middle, Last) Ston Edward ivina 19a. Informant's Name/Relationship (Type, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20(0) 3133 Connecticut Ave. A NW #1019 Washington &City or Tywn, State itam 27 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Pages ' 70 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State = 5 permit. Page Department of Important: If any injury or once. Evanstuneral Chapel-BlAir 3-10-do Forest Hill, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and A ressyl Facility RD, Timonium, MD 21093 3rd, ofty PEACE PULALTERNATIVES FUNCHAL Y CREMATION CENTER Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician week disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, any leading to initional cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner use as the burial-transit Due to (or as a consequence of): Physician/Medlcal IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 1 Live birth 2 ☐ Fetal death in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year 4☐Pregnant at time of death 5 Other (specify) P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No War Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Using Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification; To 1 ☐ Yes 2 ☑ No of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division To the Hospital or Attending 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No death. 2 Accident investigation after death Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 1 To Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D38392 D 30. Name and address of person who completed cause of death (frem 23a) (Type, Print) 32. Registrar's Signature 31. Date filed (Month, Day, Year) State MAR 1 4 2006 Registrar

		1 - For State Registrar				nt of Health and te of Death		giene Reg. No:	06 07680
Physic	ian	Decedent's Name (First, Middle, Last	•				2. Date of Dea		3. Time of Death
/Medi	cal	Regina Doris St			1		March		006 2:30 AM
Exami	ner	4a. Facility Name (If not institution, give Gilchrist Hospice			46. City	Town, or Location of Dea TOWSON	th	4c. County Balt	imore County
Funeral		5. Social Security Number 6. Se	ex 7. Age	e (In yrs. last birth		r 1 Year If Under 24 Hr			Birthplace (State or Foreign Country)
Director		213-16-9999 <sup>1</sup> Usual Residence of Decedent	□M 2 🖺 F	85 Yr	Months	Days Hours Mir	Nov.12	, 1920	Baltimore, MD.
yland		10a. State 10b. County		10c. City, Town	or Location				10d. Inside City Limits
death with the Maryland ma 23e or 28a-f ahow rreast be rictified at	ctor	Maryland Harford	County	Fores	t Hill				1 ☐ Yes 2 ☐ No
with th	Director	10e. Street and Number			10f. Zi	p Code		10g. Citizen of	·
eath v	era	3006 Stillwater C	OUTT 12. Was Decedent I	Ever in 11 C	12 Was Dass	21050	Const. V. a. a. N.		d States
ĕ = =	Be Completed by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 ☒ N			dent of Hispanic Origin? ( orify Cuban, Mexican, Pue	nto Rican, etc.)	Bla	ce - American Indian, ck, White, etc.
	by	3 ☼ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 🗌 Yes	2K) No Specify:		Specif	y: White
be filed within 72 hours ital Hygiene. Id other than "natural", avant, I're Medical Exa	etec	15. Decedent's Ed (Specify only highest gra	lucation de completed)	16a. D	ecedent's Usu Give kind of w	al Occupation ork done during most of wi use retired)	orking	16b. Kind of B	usiness/Industry
within no. Ihan	E G	Elementary/Secondary (0-12)	College (1-4or 5	i+)		se retired) Maker		Orazo	Home
Hygie ther ant, II	ပိ	17. Father's Name (First, Middle, Last)			TIONE		me (First, Middle,		
	To B	Joseph Albert Hei	ns				y Rodger		,
A PEE	-	19a. Informant's Name/Relationship (7	Type, Print)			s (Street and Number or F			
s 1 end 2 should I Health and Mer Itam 27 is marks other traumatic		Mrs.Susan S.Letsc	hin(Daught			lwater Court	Fores	t Hill,	Maryland 21050
permit. Peges 1 end 2 Department of Health a Important: if itam 27 is any injury or other tra once.		20a. Method of Disposition 1 □ Burial 2 ☼ Cremation 3 □	Removal from State	20b. Place of D cemetery,	isposition (Na crematory or	me of other place)	Date		- City or Town, State
Peg tment tant:		4 ☐ Donation 5 ☐ Other (Specify	()	Evans F		Chapel Marc	12		est Hill,MD.
Dermit. Peges 1 er Department of Hea Important: If itam: any injury or othe	h.	21. Signature of Funeral Service Licen	t mi	2. 12	Peacef	nd Address of Facility UI Alternati	ves Fune	ral&Cre	mation Ctr.,P.A
		23a. Part / En er tille disease or comp	plications that caused		2325 Y	ork Road Ti	montum, M	aryland	21093 Approximate
Obveision		show, or he in failure. Ist only in its limited in the shows a show that it is the shown in the	one cause on each lin	ne.	Str		ic or respiratory at	1651,	Interval Between set and Death
Physician /Medical		disease or condition resulting in death)	aDue to (or as	a consequence of		OKE			Hours
Examiner		Cognosticity list conditions	b						
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eath certifica ettending ph for use as th	Completed by Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	of pregnancy 2  Fetal death	2000			23d. Da	ite of delivery
the ette	sicia	in the past 12 months? 1  Yes 2 No	4☐Pregnant at		3 □Ectopic p 5 □ Other (s			Mo	onth Day Year
ed by the detached	Phy	9 Unknown							
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v requir been si should	etec	, ,	1	<u> </u>			-	′es 2□No	3 Probably 4 □Unknown
hes ge 2	를	disease					24a. Was autop	sy	Were autopsy findings available prior to completion of cause of death?
ician: Th certificete rector, pag		25. Was case referred to medical					1 Yes	2 No	1 ☐ Yes 2 ☐ No
ysician: The is certificate he director, page	To Be	examiner?	Hospital:	ent 2 🗆 ER/Outp	ationt 3 T D	Other	eath <i>Check only o</i> Home 5 🗆 Resid		no (Constant )
는 는 표		27. Manner of Death	28a. Date of Injur	ry 28b. Tin		28c. Injury at Work?	28d. Describe h		
anding F ath. or: After he funer	atle	1 Natural 5 Pending 2 Accident investigation	1	y Ye <i>ar)</i> Inji	М	1 Yes 2 No			
or Attand efter death Director: A	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inju- building, etc	ury - At home, farm c. (Specify)	, street, factor	y, office	28f. Location (S City or Tow	Street and Numb m. State)	ber or Rural Route Number,
To the Hospital or Attent within 24 hours effer death To the Funeral Director: completely filled in by the	Medical C	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	niner: On the basis of	examination and/	death occurred	l at the time, date and place, in my opinion, death occ	e, and due to the curred at the time.	cause(s) and madate and place,	anner as stated. and due to the cause(s)
o tha ithin 2 o tha omple	Meo	29b. Signature and title of certifier	and manner sta	3( <del>0</del> 0.	29	c. License number		29d. Date signe	ed (Month, Day, Year)
F ≯ F ŏ		1 Al Hash	my Hil	en uns			-	MANO	ch 9 200 h
7		30. Name and address of person who	completed cause of d	eath (Item 23a) (T	/pe, Print)		(, )	21	eh 9,2006
		W. H. Riley	GBM	( 6.	781 /	V. Charle	St. Kr	acts.	My 5120x
Sta Regist	ate	31. Date filed (Month; Day, Year)		ar's Signature	Lack !				

DHMH 17 Rev 1/2001

			Chate of Mandard / David		•	_	
			State of Maryland / Depart		ental Hygle	ne 2006	07681
			Registrar	ficate of Death	Reg.	No: UUU	07001
	Physici	an	1. Decedent's Name (First, Middle, Last)			Day Year	3. Time of Death
	/Media	al	DORIS M. SPITZNAGEL	1. Cit. T		0 0006	12:00 A M
	Examin	ier		b. City, Town, or Location of Death		4c. County of Dea	_
	Eugenel		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year   If Under 24 Hrs.	8. Date of Birth	5ALTIA 9. Bir	
	Funeral Director			Months Days Hours Min.	8. Date of Birth Month, Day, Ye 5/11/190	ar) 00	thplace (State or Foreign ountry) ARYLAND
			Usual Residence of Decedent		071111	0 1111	1107111-0
26	Maryland -f show	_	10a. State 10b. County 10c. City, Town or Locat				10d. Inside City Limits
2006 00 AM		cto	MD BALTIMORE PARKU				1 Yes 2 H0
00	with the a or 28e	Funeral Director		10f. Zip Code	10g.	Citizen of What Co	ountry?
5 5	deeth v ms 23e f.must	ra	4014 CHATEAUGAY CT.	21254		USA	
द		une	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Never Married 2 □ Married  1 □ Yes 2 □ No	s Decedent of Hispanic Origin? (Speces, specify Cuban, Mexican, Puerto F	cify Yes or No- Rican, etc.)	14. Race - Ame Bleck, Whit	
March -0036	hours efter turel', or ite	by	3 Widowed 4 Divorced If Yes, Give 10	Yes 2 No Specify:		Specify:	LITT
≥ ĕ	72 hou	ted	15. Decedent's Education 16a. Deceden	nt's Usual Occupation	166	. Kind of Business	417E Vindustry
<u>2</u>	S - 3	Completed	(Specify only highest grade completed)  (Give kin life, DO life, D	nd of work done during most of workin NOT <b>use</b> retired)	-	1	2
9 2	iled with dygiene. her ther	NO.	12 NIA KEY	TUNCH		HIRK	SRAKES
M E	be filed tel Hyg d othe event,	Be (	17. Father's Name (First, Middle, Last)	18. Mother's Name	1		
1 ×	should be nd Mente marked imatic e	ဥ	WILLIAM WHITE	ECSI	E UE	NNIS	
SpitzNagel Man Maryland 21215-0036	2 sho			Address (Street and Number or Rural			
DORIS SpitzNage	s 1 end 2 should be filed of Heelth and Meniel Hyg Item 27 is marked othe other traumatic event,		BRENDA FISCHER - DAVEHTEL 000  20a. Method of Disposition 20b. Place of Disposition		14 HUE.	5.ALTIMOL	CE, MO 21220
DORIS Saltimore,	8 ° = 5		1 Burial 2 Cremation 3 Removal from State	tory or other place)	200 200	Location - City or	1) C
戻 章	t. Pa rtmen rtent:		4 □ Donation 5 □ Other (Specify) □ AR Kwood		006	MICKU	1115
J→ E	permit. Depertumporti			Name and Address of Facility	1 7	800 HA	11 10 11 22
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the	ANS FUNERAL CH			MO 2123C/
			shock, or heart failure. List only one cause on each line.	1cer	respiratory arrest,		Interval Between Onset and Death
	Physician /Medical		resulting in death)	1000			YEARS
	Examiner		Due to (or as a consequence of):				U
		je	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury				
1	and I-transit	Examiner	cause. Enter underlying Cause (Disease or injury that initiated events c				
760,	ate be executed nysiclen and he burial-transit	EX	resulting in death) Last Due to (or as a consequence of):				
376	ate be e nysiclen he buria	Ical	d				
89	eeth certificat ettending phy I for use as the	Med	IF FEMALE:				
99 90	eth co	lan/	23b. Was decedent pregnant on the past 12 months? 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ec	ctopic pregnancy		23d. Date of de Month	Day Year
o.	the e	Physician/Med	1   Yes 2 No 4   Pregnant at time of death 5   O	Other (specify)			54,
ď.	thet the de led by the de detached to	F.	Part II. Other significant conditions contributing to death but not resulting in the under	erlying cause given in Part I.	23e. Did tobac	co use contribute t	o the cause of death?
Division of Vital Records, P.O. Box	Se Ded	d by		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			robably 4 🖫 nknown
5	w requir been s	Completed			24a. Was an	24h Wasa a	utancy findings available
Ř	The law	m d			autopsy	prior to death?	utopsy findings available completion of cause of
ta	iclan; Th certificete rector, pag	ပိ	25. Was case referred to medical	26. Place of Death	1 Yes 2	No 1 ☐ Yes	s 2□ No
<u>:</u>	ysiclan; is certific director,	0 8	examiner?	Other	ne 5 Residence	e 6 MOther (Sou	soft Las Mag
9	g Physical this	D:	27. Manner of Death 28a. Date of Injury 28b. Time of		28d. Describe how i		HOSPICE
<u>.</u>	ktending f death. ctor: After y the funer	atlo	2 Accident investigation	M 1 Yes 2 No			
<u>×</u>	r Atte	Certification:	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of Injury - At home, farm, street building, etc. (Specify)	t, factory, office 2	28f. Location (Stree City or Town, S	t and Number or R	Pural Route Number,
۵	ital o						
	To the Hospital or Attendi within 24 hours effer death. To the Funstal Director: A completely filled in by the fu	Medical	23a Continue Check only  (Check only  2 Medical Examiner: On the basis of examination and/or investigation and the basis of examination and the basis of examinat	stigation, in my opinion, death occurre	and due to the caused at the time, date	e(s) and manner a and place, and du	s stated. e to the cause(s)
	To the within 2 To the comple	Med	20h Signature and title of certifier	20n Lineaca number	104	Data singed (Man	
	7 × 7 8		DA A H A P. und	02.5205	M	Arch 10	
			30. Name and address of person who completed cause of death (Item 23a) (Type, Pri	J J J J J J J J J J J J J J J J J J J	/ / / /		, =
	5		30. Name and address of person who completed cause if death (Item 23a) (Type, Pri	D25205 int) ales St. Balto	md 21	XUS	
	Sta	ite	31. Date filed (Month, Day, Year) 32. Redistrar's Signature	3			
	Regist		MAR 1 4 2006	exe			

DHMH 17 Rev 1/2001

_			1 - For State Registrar Amend Item	State of Ma	aryland / Der	artment of I	Health and M	lental Hygi	_	07682
	Physici /Medi Examir	cal	Aa. Facility Name (If not institution, give s	treet and number)	Smith		or Location of Death	2. Date of Death Month	Day Ye	DG 0454 W
	Funeral Director		BON SECOURS HOSPI  5. Social Security Number 240-38-5255  Usual Residence of Decedent	X4 2□ E 7. Ag	e (In yrs. last birthda) 76 77 Yrs.		If Under 24 Hrs.	8. Date of Birth (Month, Day, JUNE 23	Year) ,1928	Birthplace (State or Foreign Country) NC
	the Maryland 28a-f show notified at	rector	10a. State 10b. County MD  10e. Street and Number		10c. City, Town or I	IMORE		100	g. Citizen of What	10d. Inside City Limits 14 Yes 2 □ No
9	be filed within 72 hours after death with the Maryland that Hygiene. Individual than "natural", or Itams 23a or 28a-f show of other than "natural", or Itams 23a or 28a-f show event, it is Medical Examinar must be notified at	by Funeral Director	1510 N. MOSHER ST.  11. Marital Status  1 ☒ Never Married 2 ☐ Married	REET  2. Was Decedent Amed Forces? 1 □ Yes 2 ሺ I If Yes, Give	Ever in U.S. 13	212 Was Decedent of I	Hispanic Origin? (Spe an, Mexican, Puerto		USA 14. Race - A Black, W	merican Indian, /hite, etc.
21215-0036	rithin 72 hours ne. nen "natural", e Meulical Exal	Completed by	3 Widowed 4 Divorced  15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	Year or Dates:	ite.			ng 16	Specify:  Sb. Kind of Busine	,
Maryland 21	be filed tal Hygi d othar evant,	To Be Cor	9 17. Father's Name (First, Middle, Last) LONNIE D. SMITH		L	ABORER	18. Mother's Name			CTION
	and 2 sho lealth and m 27 Is m har traum		19a. Informant's Name/Relationship (Type REGINALD SMITH/SO	*	11	32 MCKEAN		BALTIMORI	E, MARYL	AND 21217
Baltimore,	permit. Pages 1 and 2 should Department of Health and Men Important: If item 27 Is marke any injury or other traumatic: 0000.		20a. Method of Disposition  1 ★ Burial 2 □ Cremation 3 □ Re  4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service License		WOODLAWN	CEM  22. Name and Addre	3/15/ ass of Facility JAM AURENS ST	'06 E ES A. MOI		
	Physician /Medical		23a. Part1 Enter the disease, or complic shock or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	ations that caused e cause on each lin	I the death. Do not en	nter the mode of dyi		r respiratory arres		Approximate Interval Between Onset and Death
8760, 🖈	Examiner	ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as	a consequence of): a consequence of): a consequence of):					
P.O. Box 68	The law requires that the death certificate be executed its has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	ic. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal death 3	⊒€ctopic pregnanc □ Other <i>(specify)</i> _	у		23d. Date of Month	delivery Day Year
	w requires that been signed b should be deta	by	Part II. Other significant conditions cont		ut not resulting in the		ven in Part I.			e to the cause of death?  Probably 4 Dunknown
Vital Records,		e Completed	25. Was case referred to medical				26. Place of Death	24a. Was an autopsy performe	prior death	
n of	ng Phys ter this neral dii	ertification; To B	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	ospital: 1 ☐ Inpatie 28a. Date of Injur (Month, Day	ry 28b. Time	of 28c. Injui Wor	ner: 4 □ Nursing Hon			pecify)
Division	To the Hospital or Attandir within 24 hours after death, To the Funaral Diractor: Al completely filled in by the fu	O	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	building, etc			F	City or Town,	State)	Rural Route Number,
	thin 24 hosp thin 24 hou the Funa mpletely fil	Medicai	29a. Certifier (Check only one)  1 ☐ Certifying Physic 2 ☐ Medical Examination one)	cian: To the best of er: On the basis of and manner sta	examination and/or i	nvestigation, in my c	opinion, death occurre	ed at the time, date	and place, and c	lue to the cause(s)
)	, (		) Desol	79	and the second		17537		3-10	06
	Sta	tė.	30. Name and address of person who con DARSHAW, 5.5 31. Date filed (Month, Day, Year)	HLU/A	eath (Item 23a) (Type 1606 W ar's Signature	-MOUNT	toyal	Ave, 1	Zaltin	ne 21217
	Registr	_	MAR 1 4 2006	199-0-1	M. Book	des				

			1 - For State Registrar	State of I	Maryland		artmen tificate			ind M	F	Reg. No.	)6	07683
	Physici /Medic	cal	Decedent's Name (First, Middle,     Jerry Vincent S     4a. Facility Name (If not institution,	mith	a cl		45 00	Taum	Lasakias	4 Doorth	2. Date of Dea Month	Day	Year 2006	3. Time of Death
	Examir	er	St. Agnes H	ealthca	e		Bo	ulti	nore	_		Balt	ty of Death imore	City
	Funeral Director		5. Social Security Number 234-56-4325 Usual Residence of Decedent	3. Sex 7. 1⊠M 2□F	Age (In yrs. la:	st birthday) Yrs.	If Under Months	Days	If Under: Hours	Min.	8. Date of Birtl (Month, Day 8-16-1	), Year) 937	9. Birth	place (State or Foreign ntry)
	he Maryland 28s-f ahow ciffied at	Director	10a. State 10b. County  MD Anne A  10e. Street and Number	rundel		Town or Lo	1							10d. Inside City Limits 1 ☐ Yes 2 ☒No
9800	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Health and Mental Hygiene. Importants if Itam 27 is marked other than "natural", or Itama 23a or 28a-f ahow any njury or other traumatic avant, I'ra Medical Examinar must be motified at angle.	by Funeral	542 Cleveland R  11. Marital Status  1 Never Married 2 Marrie  3 Widowed 4 Divorced	12. Was Decede Armed Force d 1 12 Yes 2 If Yes, Give Year or Date	s? ⊒ No		Was Deced f Yes, spec 1 ☐ Yes	1090 Lent of Hi cify Cubar 2区 No	Specify:	gin? (Spe , Puerto l	ocify Yes or No- Rican, etc.)	Spec	A. ace - Ameriack, White, ark, White,	can Indian, etc. ite
Maryland 21215-0036	led within 72 i lygiene. her than "nat it, the Medica	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)	grade completed) College (1-4c	or 5+)	life. i	lent's Usua kind of woi DO NOT us pecto	rk done d se retired,	luring most				hcare	·
yland	ould be fi Mental H Marked ott hatte avar	To Be	17. Father's Name (First, Middle, L Richard Pliant	Smith			· · · · · · · · · · · · · · · · · · ·		Arm	inda	(First, Middle, Mullin:	S		
e, Mar	l and 2 sh Health and Im 27 is m		Ms. Amy Leigh St			542 C	leve1	and		Lir	I Route Numbe	, MD 21	.090	
Baltimore,	permit. Pages I Department of H Importent: If Its Imp injury or ot once:		20a. Method of Disposition  2OSBurial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp. 21. Signature of Funeral Service L	ecity)	te cer	nce of Dispo metery, cren 1 Have	n Mem	ther place 10 <b>ri</b> a	1 Pk	3-1	6-2006 ngleton	Glen Funera	Burni	e. MD
8760,	Physician /Medical Examiner but sicien and supply sicien and supply sicien and supply sicien and supply sicien and supply sicien and supply sicien supply sicien supply supply sicien supply supply sicien supply sicien supply supply sicien supply supply supply sicien supply su	dical Examiner	23a. Part1. En er the disease, or o shock, or heart failure. List of the shock of heart failure. List of the shock of heart failure. List of the shock of heart failure. List of the shock	a	ed the death.	Do not ent  Orce ence of):  Lun ence of):	er the mod	e of dying	g, such as	cardiac o		rest,		Approximate Interval Between Onset and Death My Nurtes
P.O. Box 6	The law requires that the death certific ete hes been signed by the ettending p page 2 should be detached for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		2 ☐ Fetal d at time of dea	leath 3	Ectopic pro Other (sp						ate of deliv	ery Day Year
	w requires that been signed b should be deta	Ď	Part II. Other significant condition	s contributing to death	n but not result	ting in the u	nderlying ca	ause give	n in Part I.			_		he cause of death?
Division of Vital Records,	To the Hospital or Attending Physician: The law r Within 24 hours after death. To the Funarel Director: After this certificate hes be completely filled in by the funeral director, page 2 sh	e Completed	25. Was case referred to medical								24a. Was a autop perfor 1 Yes	med? 2 No		opsy findings available impletion of cause of
Ž	nysicie nis cert direct	ToB	examiner?	Hospital: 1 1 hps	atient 2 E	R/Outpatien	t 3 DO	A Othe	_		<i>(Check only or</i> ne 5 ☐ Resid	-/	ther (Specif	(v)
ion o	inding Plath. ath. ir: After the	ertification:	27. Manner of Death 1 ☑Natural 5 ☐ Pending 2 ☐ Accident investiga		njury 2 Day Year)	28b. Time of Injury	M 2	8c. Injury Work 1 🗆 Y		2	28d. Describe h			
Divis	o the Hospital or Attanding Physician: within 24 hours after death. to the Funarel Director: After this certification plates illed in by the funeral director.	Certific	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	ed 28e. Place of	Injury - At hom etc. (Specily)	ne, farm, str	eet, factory	, office		2	28f. Location (S City or Tow	treet and Num n, State)	ber or Rura	al Route Number,
	tha Hoapital In 24 hours the Funarel pletely filled	Medical	29a. Certifier 1 ☑ Certifying (Check only one)  (Check only one)	Physician: To the be kaminer: On the basis and manner	s or examinatio	ledge, death on and/or in	occurred a restigation,	at the tim in my op	e, date and inion, deat	d place, a	and due to the d ed at the time, o	ause(s) and m late and place	nanner as s	stated. o the cause(s)
)	To the within 2 To the complet	Σ	29b. Signature and title of certifier  Saujay	· Viya	nagan	И			number	5	(	29d. Date sign	ed (Month,	Day, Year)
	[0		30. Name and address of person w	no completed cause of	of death (Item 2 2-M	23a) (Type,	Print)	ton	Ave	/ .	Baltin	nove,	MD	21229
	Sta Registr		31. Date filed (Month, Day, Year) MAR 1 4 2	ag. Regi	strar's Signatu	le Acas	le)							

SMITH JERRY

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First Middle Last) Month **Physician** SCHEPPSKE MAR E 0200AM ANNA. 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner MERCY MEDICAL CENTER MD N/A TIMORE If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 6. Sex **Funeral** Year) Days 1 □ M 2 □ X F 213 32 9461 70 Director 19. 1935 Maryland Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or iteme 23a or 28e-f ehow The Medical Examiner must be notified at N/AMaryland Baltimore 1 X Yes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1706 Casadel Avenue 21230 U.S. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black. White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White Be Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry i Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Clerk 9th Pharmacy permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygier Important: if item 27 is marked other th any injury or other traumatic event, Ira once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Henry Brown Amelia Murphy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tammy Smitley / Daughter 1706 Casadel Avenue Baltimore, Maryland 21230 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cedar Hill Cemetery 3/10/2006 Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Gonce Funeral Service, P.A. 4001 Ritchie Highway Baltimore, Maryland 21225 anno Part 1. Enter the disease examplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final · CONGESTIVE HEART FAILURE **Physician** disease or condition resulting in death) MONTHS /Medical Due to (or as a consequence of): Examiner CHRONIC OBSTRUCTIVE PULMONARY DISEASE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner The law requires that the death certificate be executed the attending physician and hed for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetat death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) 1 Yes 12 No been signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? HYPERTENSION 1 Yes 2 No 3 Probably 4 Unknown DIABETES 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 12 No 1 TYes 2 🗆 No completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: Injury at Work? After V □ Natural 5 Pending 1 Tyes 2 □ No 2 Accident investigation within 24 hours after death To the Funerel Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0063326 MN A. MD MERGY MEDICAL CENTER, BALTIMORE, MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DHOLAKIA MD State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Michael Smith Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Unpend item#23a PTT 27 28a-f. per ME 0855 5/5/06 TT State of Maryland / Department of Health and Mental Hygiene 06-01628 CTFor State Registrar Certificate of Death Reg. No: 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician Michael Christopher Smith 2006 06 10:09 A<sup>M</sup> March /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Harbor Hospital Center Baltimore N/A 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year Birthplace (State or Foreign Country) **Funeral** Months 1 ☑ M 2 ☐ F 216 08 7949 20 26, Director May 1985 Maryland Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Depertment of Health and Mental Hyglene. Important: if itam 27 is marked other than "natural", or items 23a or 28e-f ehoven hy injury or other treumatic event, "ita Mudical Examinat requirited at once. 1 XYes 2 No Directo N/A Baltimore Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S. 21226 1630 Plum Street Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: Specify: White Completed by 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Cashier Grocery Store 8th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Richard Smith Peggy Lockner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Peggy Lockner / Mother 7469 E. Furnace Branch Rd. Apt.A Glen Burnie, MD 21060 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, Slate 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation \_ 5 ☐ Other (Specify) Holy Cross Cemetery Baltimore, Maryland 3/11/2006 21. Signatu 22. Name and Address of Facility Gonce Funeral Service, P.A. 4001 Ritchie Highway Baltimore, Maryland 21225 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician Narcotic (Methadone) Intoxication resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner or Attending Physician: The law requires that the death certificate be executed use as the burial-transil and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 □Ectopic pregnancy ò Day Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did lobacco use contribute to the cause of death? 2 his certificate has been sign. I director, page 2 should be 2 X No Completed 1 🗌 Yes 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ★ Yes 2 □ No 24a. Was an autopsy performed? 25. Was case referred to medical examiner?
1 🕅 Yes 2 🗆 No Be 26. Place of Death (Check only one) Hospital: 1 | Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 2XER/Outpatient 3□ DOA 27. Manner of Death 28b. Time of Injury 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? After 1 Natural 5 Pending 1 ☐ Yes 21 No investigation Fnd 3/6/2006 Ind 9:50 a<sup>M</sup> 2 Accident within 24 hours after death To the Funeral Director: , completely filled in by the f unk 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
Found: residence 28f. Location (Street and Number of Rural Route Number, City or Town, State) 1630 Plum Street filled in by 4 - Homicide determined Baltimore, MD 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of 29c. License number 29d. Date signed (Month, Day, Year) OCME March 07, 2006 complet : ca e of death (Item 23a) (Type, Print) 10Kpind 111 Penn Street Baltimore, Maryland 21201 31. Date filed (Month, Day, Year) 32. Refistrar's Signature State

State Registrar

DHMH 17 Rev 1/2001

- 34 E

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day 2006 **Physician** March 11, 9:00 PM BERNICE GERTRUDE SMYTH /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore County 14202 Dove Creek Way, #101 Sparks | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year 30, 1 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1□M 20 F Yrs. 60 Maryland 220-50-2346 Director Usual Residence of Decedent with the Maryland 10c. City. Town or Location 10a State 10b County 10d. Inside City Limits 1 ☐ Yes 2√ No Maryland Baltimore County 10g, Citizen of What Country? 10f. Zip Code other than "natural", or Iteme 23a or vent, the Medical Examiner must be a 21152 IISA 14202 Dove Creek Way, #101 Pages 1 and 2 should be filed within 72 hours after death Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give <sup>Y</sup> Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White 3 ☐ Widowed 4 ☐ Divorced "natural", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Administrative Clerk Telecommunications 12 yrs 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be is marked of Gertrude Bernice McIntyre Dennis Francis Smyth, Sr. ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 500 College Avenue, Lutherville, Maryland 21093 Health i Geraldine L. Abbott (Sister) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Depertment of H
Importent: If Ite
any Injury or ot
once. 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify)

21. Signature of Fund Service Consess Dulaney Valley Mem. Grdns 3/16/2006 Timonium, Maryland 22. Name and Address of Facility
Mitchell-Wiedefeld Funeral Home, Inc. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximately 100 and 1 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician A CYTE M.1 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, reading to unmediate cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of Examiner ettending physicien and for use as the burial-transit Hospital or Attending Physicien: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 4 Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No performed? 1 ☐ Yes 2 ☐ No certificate 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဥ 1 Yes After this c 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) Certification: Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 24 hours after death.

The Funeral Director: After the further of investigation 6 ☐ Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 🗌 Homicide Certifying Physician: To the best of my knowledge death occurred at the tane, date and place, and due to the nauce(c) and manner at stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Conflier Medical (Check only one) within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and ad of person who completed cause of death (Item 23a) (Type, Print) Raymond Nze, M.D., 7801 York Road, Towson, Maryland 21204 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAR 1 4 2006

Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** March 6, 2006 BARBARA PARKS 10:50A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Manor Care Roland Park Baltimore N/A If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country)
 Maryland **Funeral** 217-46-0499 1□M XXF 59 Yrs. Director December 1,1946 Usual Residence of Decedent death with the Maryland 10a State 10b County 10c. City, Town or Location Pages 1 and 2 should be filed within 72 hours after death with the Marylan nent of Health and Mental Hygiene.
ans: If item 27 is marked other than "natural; or Items 23a or 28a-1 show ans: If item 27 is marked other than "natural; or Items 23a or 28a-1 show any or other thatmatic avent, the Medical Examine must be notified at 10d. Inside City Limits 1 ☐ Yes XXX Completed by Funeral Director Maryland | Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 6700 Parkway Road 21239 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes X \ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2**(☐)**(No White Specify 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Legal Secretary Law 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Kennard Parks Shuley Juanita Turner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sister Mary Shuley Dunn 6700 Parkway Road Baltimore, Maryland 21239 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages i Department of F Important: If ita any injury or ott once. 1 Burial 2XX remation 3 Removal from State GreenMount Cemetery 3/8/06 Baltimore, Maryland <sup>¹</sup> 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Mitchell-Wielefeld Funeral Home Inc Sonature of Funeral Service, 6500 York Road Baltimore, Maryland 21212 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final FRONTAZ Physician SYNDROME LUBE disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner anding physician and use as the burial-transit The taw requires that the death certificate be executed Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? ō Month 4☐ Pregnant at time of death Day Year 5 ☐ Other (specify) P.O. | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by TITIPROIDISM 1 ☐ Yes 2 ☐ No 3 ☐ Probably SE (ZURES 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 1 Yes 2∏ No To the Hospital or Attanding Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: Mursing Home 5 Residence 6 Other (Specify) 1 Yes 2 10 10 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred After Natural 5 Pending after death. Diractor: Af 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) within 2 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Dav. Year) D0058457 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NORTH CEASAN 821 EUTAW 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAR 1 4 2006 Registrar

#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last, 2. Dete of Deeth Month Stelle 9:00 AN MARCH 11 2006 4a Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth BALTIMORE SANDTOWN If Under 1 Year | If Under 24 Hrs 7. Age (In yrs. lest birthday) 8. Date of Birth (Month, Day, Year, 6. Sex Birthplace (State or Foreign Country) Months Days Hours 1 □ M 212 F ۷A 1915 90 DEC. 24. 10b. County 10d. Inside City Limits 1 Yes 2□ No

FUTURE CARE 5. Social Security Number **Funeral** Director 220-09-3251 Usual Residence of Deceden parmit. Pagas 1 and 2 should be filed within 72 hours after death with the Maryland Department of Haalth and Mantal Hygiena. Important: if item 27 is marked other than "naturel", or items 23s or 28s-f show any Injury or other traumstic event, the Medical Evantries must be notified at 10c. City, Town or Location BALT IMORE 10a. Stete MD Director 10e. Street end Number 10f. Zip Code 21217 1701 EUTAW PLACE Funeral 12. Was Decedent Ever in U,S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 No If Yes, Give 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: à 3 Widowed 4 ☐ Divorced Year or Dates: Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) Elementary/Secondary (0-12) College (1-4or 5+) LPN 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ESTELLE BALL CURRIE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 537 SANFORD PLACE, BALTO., MD 21217 MARY E. NEAL/SISTER 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) WOODLAWN CEMETERY 3/16/06 JAMES A. MORTON & SONS F.H, INC 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 1701 LAURENS STREET, BALTIMORE, MD 21217 anus Um 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, **Physician** /Medical

Examiner

**Physician** 

/Medical

Examiner

Examiner physician and s tha burial-transit Physician/Medical a attanding ph d for usa as ti ed by the a signed b \$ Completed

The law raquiras that the death cartificate be executed cata has bean sig , paga 2 should b this cartificata To the Mospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this cartific: complataly filled in by the funeral director,

Be

2

Certification:

Medicai

25. Was case referred to medical

1 ☐ Yes 2 ▼No

27. Menner of Death 1 Death

2 Accident 3 Suicide

Division of Vital Records, P.O. Box 68760,

Shock, or near failure. List	only one cau	ise on each line.			Onset and Death
Immediate Ceuse (Final disease or condition resulting in death)	е	METASTATIC  Due to (or es a consequence of):	ADENO	CA Colo	Months
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	<b>6</b>	Due to (or es e consequence of):			
Cause (Disease or injury that initiated events resulting in death) Last	c	Due to (or as e consequence of):			
		ng to death but not resulting in the underlying cause	given in Part I.		ntribute to the cause of death'
ANEMI	A			1 □ Yes 2 🗹 No	3 ☐ Probably 4 ☐ Unknow
				24a. Was an autopsy performed?	24b. Were autopsy findings aveilable prior to completion of cause of death?

Other:

1 Tes

2 🗆 No

28c. Injury at Work?

6 Could not be determined 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner steted. 29a. Certifier 29b. Signetare and title of certifier 29c. License number 30. Neme end address of person who completed cause of deeth (Item 23e) (Type, Print) ima

1 Inpatient

Dete of Injury (Month, Dey Year)

29d. Date signed (Month, Dev. Yeer)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

2 No

1 ☐ Yes

4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

28d. Describe how injury occurred

26. Place of Death (Check only one)

10g. Citizen of What Country? USA

Specify.

HEALTH

16b. Kind of Business/Industry

20c. Location - City or Town, State

BALTIMORE, MD

14. Race - American Indian.

BLACK

Black, White, etc.

1 ☐ Yes 2 ☐ No

V. Eutaw ST.21

State Registrar 31. Dete filed (Month, Dey, Year) MAR 1 4 2006

5 Pending

investigation

32. Registrer's Signature

2 ER/Outpatient 3 DOA

28b. Time of

State of Maryland / Department of Health and Mental Hygierie Certificate of Death 2 Date of Death 3. Time of Death 1 Decedent's Name (First, Middle, Last) Month 3.41 a Mar 11, 2006 Physician Ahmad G. Thomas /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner **Baltimore** 3139 Elmora Avenue If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) Mar 25, 1960 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number 6 Sex **Funeral** Months Days Hours 1**X** M 2 □ F Maryland 45 219-86-2234 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or itema 23a or 28a-f show eny injury or other traumatic event, the Medical Exam or must be notified at once. 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b County Yes 2 No **Baltimore** N/A Maryland Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21223 3139 Elmora Avenue Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Black Specify: Specify: δ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Coca Cola Company Elementary/Secondary (0-12) College (1-4or 5+) Fork Lift Operator 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Shirley Thomas Lawrence Thomas 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3139 Elmora Avenue Baltimore, Maryland 21213 Shirley Thomas Mother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 03/13/06 Catonsville, Maryland Metro Crematory, Inc. 5 ☐ Other (Specify) 4 Donation 22. Name and Address of Facility
Estep Brothers Funeral Service, P of Juneral Service Lic 1300 Eutaw Place Baltimore, Md 21217 se, or complications that caused the List only one cause on each line. Approximate Interval Between Onset and Death death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part1. Enter the disease shock, or heart failure. Immediate Cause (Final **Physician** Due to (or as a consequence of) disease or condition resulting in death) /Medical Examiner Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or de a conled by the attending physicien and detached for use es the buriat-transit that initiated events resulting in death) Last Box 68760. Physician/Medical the ! IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal de 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy 2 Fetal death Month Day in the past 12 months? 5 Other (specify) 4□Pregnant at time of death ☐Yes 2☐No Division of Vital Records. P.O. 9□ Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 🗌 No 3 Probably 4 □Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy has 20 No 1 ☐ Yes ill To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: Hospital: 1 Yes 2 No 1 🗌 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 □Other (Specify) this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 27. Manner of Death After t Certification: 1 Natural 5 Pending investigation after death. 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 1 \_\_ Certifying Thysician: To the best of my knowledge death occurred at the time date and place and due to the mause(s) and manner an stated 2 \_\_ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier cal (Check only within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D0022004 3-13-06 30. Name and address of person who complete cause of death (Item 23a) (Type, Print) VD 21202 Beltimo 1830 ٤ nonunt 32 Registrar's Signature 31. Date filed (Month, Day, Year) State MAR 1 4 2006 Registrar

		Please Type or Print in Black Indelible Ink. Ens State of Maryland / Department of Health  1 - State Registrar  Certificate of Death	and Mental H	•
Physici /Medi		1. Decedent's Name (First, Middle, Last)	2. Date of Month	Death 3. Time of Death
Examir Funeral		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location  Sinal Hospital of Baltimore  Baltimore	e city	4c. County of Death  n/a  Birth Day, Year) 7-54  4c. County of Death Country  9. Birthplace (State or Foreign Country) Va.
be filed within 72 hours after death with the Maryland lat hygiene. In hygiene. In other than "natural", or itama 23s or 28s-1 show be ovent, the Marcinal Expendition in the first late in the first late and the control of the contr	ineral Director	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits 1 √ Yes 2 □ No  10g. Citizen of What Country? USA
d Z1Z13-UU36 filed within 72 hours afte Hygiene. ther then "nature!", or it int, the Macinal Exemin	Completed by Funeral Director	1 Never Married 2 Married 1 Secretary Specification (Specify only highest grade completed)  1.5 Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)  9 th  Cook	fy: ost of working	specify: African-American  16b. Kind of Business/Industry  Food Service  ddle, Maiden Sumame)
d be ental	To Be	to 17. Father's Name (First, Middle, Last)	leanor Fo	ord
Baltimore, Mary permit. Pages 1 and 2 shoul Department of Health and M Important: If them 27 Is mart any injury or other traumati once.		Susan D. Cosby/Aunt  20a. Method of Disposition  1 \( \text{Normal} \) Burial 2 \( \text{Coremation} \) Coremation 3 \( \text{Removal from State} \)  4 \( \text{Donation} \) 5 \( \text{Other (Specify)} \)  21. Signature of Teneral Serve a Licenson  20b. Place of Disposition (Name of cemetery, crematory or other place)  King Mem. Park  22. Name and Address of Fac	Date 3-16-06 polityWylie F	, Balto. MD 21217  20c. Location - City or Town, State  Woodlawn, MD  /H PA of Balto. Co.
Physician /Medical Examiner	Examiner	Due to (or as a consequence of):  Cholery sults	Rd., Ran as cardiac or respirato emomheg	ry arrest, MD 21133 Approximate Interval Between Onset and Death Iday  I weelt
box bb/cd	Physician/Medical E	_		23d. Date of delivery Month Day Year
(ecords, relatives that has been signed be de	Completed by Ph		24a. V	Did tobacco use contribute to the cause of death?  Yes 2 No 3 Probably 4 Unknown  Was an autopsy prior to completion of cause of death?
n of Vital ng Physician: ther this certifical uneral director, p	Certification: To Be Co	25. Was case referred to medical examiner?  1	28d. Descr □No 28f. Locatio	CONTRACTOR OF THE PARTY OF THE
DIVISIO To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical Cert		and place, and due to leath occurred at the til	the cause(s) and manner as stated.
7		Mhant MD RESIDEN  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	7-15794	March 10 2006 F BALTIMORE
Sta Regist DHMH 17 Rev 1/2		MAR 1 4 2006		

		-	Please I  For State Registrar	State of Maryland / Depa Cei			ne nns	07692
	Physicia /Medic	an	1. Decedent's Name (First, Middle, Last)  John C. Victor		Lu ch T	2. Date of Death Month March	Day Year 11, 200 (	
*	Examin	er	4a. Facility Name (If not institution, give s Union Memorial H	lospital	4b. City, Town, or Location of Death Baltimore		N/A	
	Funeral Director		217-30-0077	7. Age (In yrs. last birthday)  7. Age (In yrs. last birthday)  Yrs.	If Under 1 Year	(Month, Day, Y	9. Birth Cou 9,1951 Cal	place (State or Foreign intry) ifornia
	Aaryland f ehow ed at	o	Usual Residence of Decedent  10a. State 10b. County  Maryland Baltimo	ore Rosedale				10d. Inside City Limits 1 ☐ Yes
	vith the P	Director	10e. Street and Number		10f. Zip Code	10g	. Citizen of What Cou	intry?
	death v	Funerai	7102 East Biddle S		21237 Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert	pecify Yes or No-	USA 14. Race - Amer	ican Indian,
920	ours after or rel', or Iter Examiner	þ	1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 X No	1 ☐ Yes 2 ☑ No Specify:		Black, White	ite
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any njurry or other traumatic event, the Madical Examinar must be notified at ADES.	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0·12) 12	(Give	dent's Usual Occupation kind of work done during most of wor DO NOT use retired) isabled		b. Kind of Business/I Disabled	ndustry
/land	Mental Hyg Mental Hyg arked other atic event,	To Be C	17. Father's Name (First, Middle, Last) Charles Victor		Jean H	ne (First, Middle, Ma • Kenny		
Mar	nd 2 sho alth and 1 27 le mu ir trauma		19a. Informant's Name/Relationship (Ty) Gary Victor		ng Address <i>(Street and Number or Ri</i> 21 W. 35th Street			
Baltimore,	Pages 1 e ent of Hei nt: If item ry or othe		20a. Method of Disposition  1 1 Burial 2 □ Cremation 3 □ R  4 □ Donation 5 □ Other (Specify)	emoval from State 20b. Place of Dispo cemetery, cre Parkwood	osition (Name of matory or other place) d Cemetery 3/1		c.Location-City or 1 11timore, 1	
Baltii	permit. ? Departm Importar any njur		21. Signatur of Funeral Service License	Henss 2	2. Name and Address of Facility Burgee—Henss—Seit: 3631 Falls Road	z Funeral Baltimore,	Home, Inc Maryland	. 21211
	Physician		shock, or heart failure. List only or Immediate Cause (Final disease or condition	cations that caused the death. Do not en ne cause on each line.	ter the mode of dying, such as cardial	c or respiratory arrest	( <sub>4</sub>	Approximate Interval Between Onset and Death
Ĺ	/Medical Examiner		resulting in death)	Due to (or as a consequence of):  UND SEPSIS				6dags
/	cuted Id ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consequence of):  A well Ren	al failure			6 days
8760,	icate be executed physicien and s the burial-transit	cai	resulting in death) Last	Due to (or as a consequence of):  AnaSav Ca				
P.O. Box 68	death certif e attending od for use a	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		□Ectopic pregnancy □ Other (specify)		23d. Date of deli- Month	very Day Year
	puires that n signed b uld be deta	þ.	Part II. Other significant conditions con	ntributing to death but not resulting in the	underlying cause given in Part I.		cco use contribute to	
of Vital Records,	The law requires that the sete hes been signed by th page 2 should be detache	Completed				24a. Was an autopsy performe	prior to death?	topsy findings available completion of cause of
/ita	Physician: Th r this certificete ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:	Other	ath (Check only one)	10	
on of	S D	tion: To	27. Manner of Death 1 Proatural 5 Pending	10 phpatient 2 ☐ ER/Outpatie 28a. Date of Injury (Month, Day Year)  28b. Time of Injury	SIL 3 DOA 4 INUISING	dome 5 ☐ Residen 28d. Describe how	ce 6 ⊡Other (Spece r injury occurred	ofy)
Division	To the Hospital or Attending Phwithin 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm, s building, etc. (Specify)	treet, factory, office	28f. Location (Stre City or Town,	eet and Number or Ru State)	iral Route Number,
_	Hospital	ledical C	29a. Certifier 1 Certifying Phy (Check only one)	sician: To the best of my knowledge, dea ner: On the basis of examination and/or i and manner stated.	ath occurred at the time, date and place nvestigation, in my opinion, death occ	e, and due to the cau urred at the time, dat	ise(s) and manner as e and place, and due	stated. to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	(511) 113	29c. License number		d. Date signed (Monti	-
			> Sauke	ompleted cause of death (Item 23a) (Type	AT 24389	16 /	March 11,	, 2006
_	. 1		Shaker Eid	MD Union	Memorial Ho	spital	MD	
	St Regist	ate rar	31. Date filed (Month, Day, Year)  MAR 1 4	32. Registrar's Signature	losele			

DHMH 17 Rev 1/2001

ORIGINAL

		State of Maryland / Dep	artment of Health and Natificate of Death	Mental Hygien	<b>9</b> 006 07693
27		Registrar  1. Decedent's Name (First, Middle, Last)	Tuncale of Dealif	Reg. N	3. Time of Death
Physici	an	Patrick Richard Vitek, Sr.		Moph	ay Year 5:20 AM
/Medic		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Lecation of Death	0 10	County of Death
Examin	er	Franklin Sallara Hospital	Kreedale.		Bultimore.
- Funeral		5. Social Security Number 6. Sex 7. Age (In yes, last birthday	if Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth	9. Birthplace (State or Foreign
23 Director		219-38-7657 XX 2 62 Yrs.	Mortals Days Hours Will.	06-09-194	3 Maryland
and w		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or L	ocation		10d. Inside City Limits
/anyia	ō				1 ☐ Yes 2 ☐ No
the the rough	rect	Maryland Baltimore Baltimore  10e. Street and Number	10f. Zip Code	10g. C	Citizen of What Country?
3a or	0	24 Springtowne Circle	21234		.S.A.
ING 21215-0036  be filed within 72 hours after death with the Maryland ital Hygiene. d other than "natural", or iteme 23s or 28e-f show event, the Medical Examinar must be notified at	Funeral Directo		Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	pecify Yes or No-	14. Race - American Indian,
after or Ite	/Fu	1 □ Never Married 2 Married 1 Yes 2 □ No	1 ☐ Yes 2 ☑ No Specify:	nican, etc.)	Black, White, etc.  Specify: White
Ural;	d by	3 □ Widowed 4 □ Divorced Year or Dates:			WILLES
n 72 n	Completed	(Specify only highest grade completed) (Given life.	edent's Usual Occupation e kind of work done during most of work DO NOT use retired)	ang 16b.	Kind of Business/Industry
d 21215- filed within 72 Hygiene. other than "nater, the Medic	mo	Elementary/Secondary (0-12) College (1-4or 5+)	ager	St	orage Company
Hygin other	Be C	17. Father's Name (First, Middle, Last)		ne (First, Middle, Maide	
	To B	Anthony Joseph Vitek, Sr.	Mary Agn	es Fuchs	
2 short and half			ing Address (Street and Number or Rui		
			pringtowne Court,	41 44	
Baltimore, Dermit. Pages 1 ar Department of Hea mportant: If Item: any injury or other		1) X Buriai 2 Cremation 3 Hemoval from State	ematory or other place)		Location - City or Town, State
ti Pay tmen tmen tant:		4 ☐ Donation 5 ☐ Other (Specify) Gardens			ltimore, MD
Baltimor permit. Pages Department of I Important: If Its any injury or o			2. Name and Address of Facility Mille-r-Dippel		Belair Road more, MD 21206
		23a Part1. Enter the disease, or complications that caused the death. Do not en			Approximate
Physician		shock, or lear failure. List only one cause on each line.	ed annua collas		Interval Between Onset and Death
/Medical		disease or condition resulting in death)  Due to (or as a consequence of):	rdiomyopathy		
Examiner		C.A.D			
V 70 .≅	Iner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury			
ecute and trans	Examlner	Cause (Disease or injury that inflated events resulting in death) Last  C.  Due to (or as a consequence of):			
icate be executed physicien and s the burial-transit		Due to (or as a consequence of).			
Hecords, P.O. Box 68/60, Company of the law requires that the death certificate be executed the has been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	edical	d			
BOX 6 eath certification attending p	N/M	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy			23d. Date of delivery
G for	Icla	in the past 12 months?  1 Ves 2 No.  4 Pregnant at time of death 5	□Ectopic pregnancy □ Other (s <i>pecify</i> )		Month Day Year
at the de	hys	9 Unknown			
IS, F	Completed by Physician/Me	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.		use contribute to the cause of death?
COLD: w require been sig should t	ted	7.4.0.		1 ♥Yes	2 No 3 Probably 4 Unknown
Records, he law requires t s has been signe ige 2 should be t	nple			24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
	S			performed?	death? 1 Yes 2 No
Vital F	Be	25. Was casa referred to medical examiner?  Hospital:	Other	th Check only one)	
Of Phys rathis	. To	1 Mainpatient 2 EH/Outpatie	int 3L DUA 4L Nursing Ho	ome 5 Residence 28d Describe how in	
DIVISION OF I or Attending Phy after death.  Director: After this in by the funeral d	Certification:	27. Mano of of Death 11. Natural 5 Pending 2 Accident investigation 28a. Date of Injury (Month, Day Year) Injury	Work? M 1 □ Yes 2 □ No		
VISIO Attendi	III CE	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Pface of Injury - At home, farm, s building, etc. (Specify)	treet, factory, office	28f. Location (Street : City or Town, Sta	and Number or Rural Route Number,
rs afte	Cert	building, stc. (Specify)		ONY OF TOWN, OLD	
DIVISION Of VITA To the Hoepitel or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director,		29a. Certifier (Check crify  2 Medical Examiner: On the basis of examination and/or in	th occurred at the time, date and place, nvestigation, in my opinion, death occur	and due to the causer rred at the time, date a	(s) and manner as stated. nd place, and due to the cause(s)
o the ithin 2 o the implet	Medical	one) and manner stated.  29b. Signature and title of certifier	29c. License number		Date signed (Month, Day, Year)
F 2 E 3		Ward El-William	2 4 -	3	1/2/06
6		30. Name and address of person who completed cause of death (Item 23a) (Type	D61251	0	enterte
19	3	Dr. Wassim EL-Hitti 9000 Frank	In Square Driv	¿ baltin	note, md 21237
Sta		31. Date filed (Month, Day, Year) \$2. Registrar's Signature	ALD.		
Registr	ar	Dr. Wassim EL-Hitti acco Frank 31. Date filed (Month, Day, Year) \$2. Registrar's Signature MAR 1 4 2006	<b>OF</b>	-	

			1 - For State Registrar	State of N	laryland		nt of Health te of Death			ene	06	07694
E	Physicia		Decedent's Name (First, Middle, Las     ELLA	P		WOOD		2	Date of Death Month	Day OS	2°06	3. Time of Death 2.4 2 PM
	/Medic Examin Funeral Director		4a. Facility Name (If not institution, give BON Sec 9.5. Social Security Number 6. S. 317-21-3914 1  Usual Residence of Decedent	ours	HOSP Age (In yrs. Asst	tal	er 1 Year If Unde	of Death			9. Birthp	lace (State or Foreign
98	hours after death with the Maryland tural', or Items 23e or 28e-f show at Exertinal must be trufffed at	y Funeral Director	10a. State 10b. County  Maryland 10e. St/eet and Number  2567 W. La  11. Marital Status  1 Never Married 2 Married	Tayet  12. Was Deceder Armed Force: 1   Yes   Sive	Le Antitever in U.S.	ve. c	Tip Code  2 / 2 / 4  edent of Hispanic O ecify Cuban, Mexica  2 No Specify			14. F	of What Coun	an Indian,
land 21215-0036	a filed within 72 if Hygiene. other than "nai	To Be Completed by	3 Widowed 4 Divorced  15. Decedent's Ec (Specify only highest gra  Elementary/Secondary (0-12)  17. Father's Name (First, Middle, Last)	Year or Dates lucation de completed) College (1-40	1	6a. Decedent's Us (Give kind of v life. DO NOT	ual Occupation work done during mo use retired)	ost of working	First, Middle, M	6b. Kind o	DIO of Business/Inc	ack Justry Fal
Baltimore, Marylan	permit. Pages 1 and 2 should be Depentment of Health and Menta Important: If Item 27 Is marked any injury or other traumatic es <u>once.</u>	T	19a. Informant's Name/Relationship (1)  19a. Informant's Name/Relationship (2)  20a. Method of Disposition  20a. Method of Disposition  20a. Method of Disposition  20a. Method of Disposition  20a. Method of Disposition  21a. Sign sture of Funeral Service Ucer	Type, Print) Lau Ware Removal from State)	19hte.)	19b. Mailing Addre	ame of other place)  Torest  and Address of Face	ayet 3/16/	te Aug	oc. Location	wn, State, Zip alto on - City or To ng S ne P. A	Md, 21216 own, State Mills, Md
St.	Physician /Medical Examiner	Examiner	23a. Party Enter the dispase, or com software failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	a. PUL r Due to (or a  Due to (or a	NONA as a consequent  TE as a consequent	RY E	MBOL' BRO-V	12 M	JLAR	A 60	î DENT	Approximate Interval Between Onset and Death I hour R
O. Box 68760,	Physician: The law requires that the death certificate be executed this certificate has been signed by the ettending physicien and ral director, page 2 should be detached for use as the buriat-transit	Physician/Medicai Exan	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes   2 D No 9   Unknown	Due to (or a d	as a consequent	ice of):	pregnancy				Date of deliver	
Records, P.O.	w requires that t been signed by should be deta	Completed by Ph	Part II. Other significant conditions of	ontributing to death	_	ng in the underlying	_	t I.	1 🗆 Yes	2 🗆 No	o 3 ☐ Prob	ne cause of death?
ital Rec	ian: The law rtificate has b stor, page 2 s	0	25. Was case referred to medical				26. Pla	ce of Death (	24a. Was an autopsy perform 1 Yes 2	ed?	death?	psy findings available inpletion of cause of 2 No
of V	Physici this ce al direc	To B	examiner? 1 Tes 2 No 27. Manner of Death		itient 2 ER	VOutpatient 3  Bb. Time of			e 5 Resider			γ)
Division of Vital	To the Hospitel or Attending Physicien: The law within 24 hours after death.  To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2	Certification;	Name of Death  Name o	28e. Place of		Injury  M a, farm, street, fact	28c. Injury at Work? 1 ☐ Yes 2 [ ory, office	□No		eet and Nu		al Route Number,
	he Hospite in 24 hours he Funerel bletely filler	Medical C	29a. Certifier 1 Certifying Pt (Check only one) 2 Medical Example	ysician: To the be niner: On the basis and manner	of examination	edge, death occurr n and/or investigati	ed at the time, date a on, in my opinion, de	and place, areath occurred	d at the time, da	te and pla	ce, and due to	the cause(s)
	within To the comp	Σ	29b. Signature and title of certifier	am ma			DOO 15	780	M	ARCT	gned (Month,	2006
	3 1		30. Name and address of person who USHATAIN 1	completed cause o	f death (Item 2)	3a) (Type, Print)	BON SE	FCOU T. R	RSF	tus 1	A TIG	1223
	Sta	ite	31. Date filed (Month, Day, Year)	32. Flègi	strar's Signatur	e d'arth	,					

	1651	V W		Please T	ype or Print in Bl	ack Indelib	le Ink. Ensu	re All	Copies A	re Legible.		
	stopher	W		Unpend item#23	37,28a f perME.0	3854 4/20/06 7 Departme	nt of Health a	and Me	ntal Hygie	ne o o o	0 7	0.5
RJD		•	For State Registra	r.			te of Death		Reg	ZHIID	UIT	06(
				Name (First, Middle, Last)	1.1.1			2	Date of Death Month	Day Year	3. Time	of Death
11	Physicia /Medic		Chr	istophe	r Wate	rs			March 07	, 2006	0942	2 A. M
	Examin	er		ame (If not institution, give s			y, Town, or Location o	ol Death		4c. County of Dea	th /	
0			5. Social Secu	Agnes Hospi			timore	24 Hrs. 8	. Date of Birth	9. Bir	thplace (State	e or Foreion
36	Funeral Director		212-7		M 2□F	Yrs. Month:		Min.	(Month, Day, Y	00/0 MC	Lrula	1
1				nce of Decedent					201111 17 00			
	anylar ehow	<u>_</u>	10a. State	10b. County	10c. City,	Town or Location					10d. Inside	es 2 No
	ith the Marylar or 28a-f ehow	ecto	Maryla	nd NA		100	10re lip Code		100	. Citizen of What C		
	72 hours after death with the Maryland 'natural', or Iteme 23a or 28a-f ehow dical Exprident must be nottilled at	by Funeral Director	10e. Street ar	2 Adoll	Torrado	Apt 101.2	-2122	G	109	11 <	A	
	ne 23	era	11. Marital St	atus	12. Was Decedent Ever in U.S		edent of Hispanic Original Cuban, Mexican	gin? (Speci	fy Yes or No-	14. Race - Am		
မွ	or iter	표		r Married 2 Marned	Armed Forces? 1 ☐ Yes 2 No If Yes, Give		ecify Cuban, Mexican  2 No Specify:	n, Puerto Hi	can, etc.)	Black, Whi	te, etc.	,
21215-0036	irai', c		3 ☐ Wido	wed 4 Divorced	Year or Dates:					Specify: B	lack	
5-0	natu rutica	Completed		15. Decedent's Educ (Specify only highest grade	cation completed)	16a. Decedent's Us (Give kind of v life. DO NOT	vork done during most	t of working	16	b. Kind of Business	/Industry	
12	within ene. then "	E D	Elementary	(0-12)	College (1-4or 5+)	1110. DO 1101	1 A			N/A		
<b>q</b>	Hygin of the out,	ပိ	17. Father's N	Name (First, Middle, Last)	11/2	N	18. Mothe	er's Name (	First, Middle, Ma	iden Sumame)		
an	fental fental rked r	To Be					unk Se	9416	oia.	Naters	5	
Maryland	and N	, 1	19a. Informa	nt's Name/Relationship (Ty)	00, Print) (mother)	19b. Mailing Addre	ss (Street and Numbe	er ok Rural I	Route Number, C	ity or Town, State,	Zip Code)	
	end 2 palth n 27 i		MS,	Seguora	Waters	4302	Adelle	ler	race	303 Bal	to Md	21229
ore	of H of H if iten		20a. Method	of Dispo&ition al 2⊠Cremation 3□R	COL	nce of Disposition (Ametery, crematory of	ame of other place)	2/15 Dat	20	c. Location - City or	Town, State	
Baltimore,	permit. Pages I and 2 should be filed within 72 hours after death with the Maryla Depertment of Health and Mental Hygiene. Important: if Item 27 ie marked other then "natural", or Iteme 23a or 28a-f ehoventy injury or other treumatic event, the Mudical Exprictment must be notified at once.			ation 5 Other (Specify)	Gre		(rematory	7112	2006	Balto.	Md.	
Baj	Depermine Deperm		21. Signatur	of Funeral Service License	P. D.	JOSEI	and Address of Full	SS F	unera	1. Home	P.A.	
			23a, Party, F	Enter the disease, or compli	cations that caused the death.	Do not enter the m	W   NOTTH	cardiac or i	respiratory arrest	Ma. 21	Approxin	nate
	-		shock, Immediate C		cations that caused the death.				,		Interval E Onset ar	
	Physician /Medical		disease or co resulting in d	ondition	Sudden unexpla-		п ппапсу		· · ·			
	Examiner					,						
	D =	ner	if any, leading cause. Enter	list conditions, g to immediate r Underlying	Due to (or as a conseque	arida of):						
	executed en and irial-transit	Examiner	Cause (Diseathat initiated resulting in d	ase or injury events	. Pue to (es en e contengue							
60,	be ex icien a	-			Due to (or as a conseque	siice oi).						
9289	phys phys s the	dic										
Box (	certif nding use a	Z/Me	IF FEMALE:	cedent pregnant 2	3c. If yes, outcome of pregnan	су				23d. Date of de	livery	
ä	death e ette d for	cla	in the p	ast 12 months? s 2 □ No	1 Live birth 2 Fetal of 4 Pregnant at time of dea					Month	Day	Year
P.O.	by thatache	Physician/Medica	9 □ Uni		9□ Unknown			_				
	es tha igned be de	by F	Part II. Other	significant conditions cor	ntributing to death but not resul	ting in the underlying	cause given in Part I		1	co use contribute t		10
ord	requir een s	ted							-	2 □ No 3 □ P	robably 4	Alouknown
ec	e taw has b	Completed							24a. Was an autopsy performe	prior to	utopsy lindin- completion o	as available if cause of
a F	n: Th icete r, pag								1 Yes 2		s 2 No	
Division of Vital Records,	sicial certificacto	o Be	examiner	e referred to medical	lospital: 1 ☐ Inpatient 2 分E	FVOutpatient 3□	Othor		Check only one)	e 6 □Other (Spe	nciful	
Q	g Phy er this	-	27. Manner o	of Death	+	28b. Time of	28c. Injury at Work?		d. Describe how		eny,	
Ö	ath. r: Aft	atlo	1 □ Natu 2 □ Acci	dent investigation		Find 9:10 at	1 ☐ Yes 2X☐	No u	nk			
ivis	r Atte	Certification:	3 ☐ Suic 4 ☐ Horr		28e. Place of Injury - At hon building, etc. (Specify)	ne, larm, street, lact	ory, office		City or Town,	et and Number or P State) 4302 Ad	elle te	umber.
0	urs aff				Find at resid	dence			pt. 303 Ba	ltimore, M	)	
	To the Hoepital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Funeral Director: After this certificete has been signed by the ettending physici completely filled in by the funeral director, page 2 should be detached for use as the bu	edical	29a. Certifie (Check one)	r 1∐ Certifying Phys only 2☐ Medical Exami	sician: To the best of my know ner: On the basis of examination and manner stated.	rledge, death occurre on and/or investigati	ed at the time, date an on, in my opinion, dea	nd place, an ath occurred	nd due to the cau d at the time, date	se(s) and manner a and place, and du	s stated. e to the caus	e(s)
	o the o the omple	Mec		re and title of certifier	and mainler stated.		29c. License number		290	. Date signed (Mon	th, Day, Year	
	- s - ō		1	his hi.	my		0.C.M.E.		M	arch 08,	2006	
	NY		30. Name an	1 /	empleted cause of death (Item	23a) (Type, Print)						
	U ·		L	ING LI,	la 19	1	11 Penn St	treet,	, Baltim	ore Maryl	and 21	.201
	Sta		31. Date filed	(Month, Day, Year)	32 Registrar's Signatu							
	Regist	ar		MAR 1 4 2006	Same 1	Sarite						

			1- State of Maryla Registrer		partment of He ertificate of L			giene Reg. No.	006	07696				
			Decedent's Name (First, Middle, Last)				2. Date of De	ath		3. Time of Death				
	Physici: /Medic		Dale (nmn) Willoughk	эy			Month	Day L 15	7, 200	68:50 AM				
	Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	Location of Death			County of De					
			Citizens Nursing Ho	me	Houred	le Grac	e	1	-1ar-50	rd				
	Funeral		EOO 10 0410 1⊠M 2□E	vrs. last birthda	y) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	th y, Year)		rthplace (State or Foreign country)				
	Director		502-12-9418	Yrs.			Jan. 7,	1926	5 NO	orth Dakota				
	/land		10a. State 10b. County 10c.	. City, Town or	Location					10d. Inside City Limits				
	Mary Firsh	tor	Maryland Harford		Ede	gewood				1 ☐ Yes 2X No				
	th the	Director	10e. Street and Number		10f. Zip Code			10g. Citiz	zen of What C	ountry?				
	23a	al	2312 Shannon Road		2.	1040			USA					
	r dea	Funeral	11. Marital Status 12. Was Decedent Ever in Armed Forces?	n U.S. 1	<ol> <li>Was Decedent of His If Yes, specify Cubar</li> </ol>	spanic Origin? (S	pecify Yes or No o Rican, etc.)	- 1	4. Race - Am Black, Wh					
36	s afte	by F.	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🛂 No If Yes, Give Year or Dates:		1 ☐ Yes 2X No	Specify:			Specify: Wh					
21215-0036	hour	ed b	3 ☐ Widowed 4 ☒ Divorced Year or Dates:	16a Da	cedent's Usual Occupa	ition		16b Kir	nd of Busines	Andueta				
15	n "ne	Completed	(Specify only highest grade completed)	(Gi	ive kind of work done d b. DO NOT use retired)	uring most of wor	king	TOD. IV.	id of busines	sindustry				
212	d with giene	mo:	Elementary/Secondary (0-12) Coflege (1-4or 5+)	Ra	ncher			Agr	cicultu	re				
9	ould be filed with Mental Hygiene. Brked other than Bild event, the	BeC	17. Father's Name (First, Middle, Last)			18. Mother's Nan			Sumame)					
<u>yla</u>	should be filed within 72 hours after death with the Maryland nd Mental Hygiene. In marked other than "naturel", or items 23e or 28e-f show umatic event, it a Medical Exactical returns the incition at	ᄓ	John Clint Willoughby			Regi	na L. No	oss						
Maryland	C1 60 00		19a. Informant's Name/Relationship (Type, Print)		ailing Address (Street a									
	1 and 2 Health em 27		Eileen F. Willoughby, Executor  20a. Method of Disposition 20		2 Shannon I		gewood,		Land cation - City o	21040				
چ	ages or of the				rematory or other place									
altimore,	artme artme ortant injury		'4 □ Donation 5 □ Other (Specify)  21. Six alure of Funeral Service Licensee		Service Com	2.1			ion, ma	ryland				
Ba	permit. Pages Department of I Important: If ite any injury or of		Mille McCom o Four	7	22. Name and Address McComas Fu	neral Ho	me, P.A.		7.	7 01000				
			23a. Part1. Enter the disease, or complications that caused the d	leath. Do not	1317 Cokesh enter the mode of dying	DUTY ROAD	or respiratory a	rest,	_Maryı	and 21009 Approximate Interval Between				
L.	Pnysician		3a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac of respiratory arrest, shock, or head fellure. List only one cause on each line.  Interpretate Cause (Final Septice might be asset or condition a Septice might be asset or condition a Septice might be asset or condition a septiment of the cause (Final Septiment).											
	/Medical		resulting in death)  a  Due to (or as a con-		77114					8 days				
п	Examiner		Sequentially list conditions, b.	Sim	intis					8 days				
X	P #	Iner	rt any, leading to immediate  Cause. Enter Underlying	sequence of):						0				
100	and and	Examiner	Cause (Disease or injury that initiated events c	sequence of):										
8760,	icate be executed physician and s the burial-transit	al E	330 10 (0) 430 4 500	soquomos on,										
687	ficate physics the	edlcal	d											
Box	leath certific attending p	Physiclan/M	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pre					2	3d. Date of de	elivery				
m	death e atte	icla	in the past 12 months?		3 ∐Ectopic pregnancy 5 ☐ Other <i>(specify)</i>				Month	Day Year				
P.O.	at the	hys	9 Unknown 9 Unknown											
	The law requires that the death certif ate has been signed by the attending bage 2 should be detached for use as	by	Part II. Other significant conditions contributing to death but not A En at felleral attem	-	underlying cause give	n in Part I.				to the cause of death?				
oro	w require been si	Completed	THE TENERS	, (	. دورا		1	res 21/2		robably 4 🗀 Unknown				
Sec.	e law has b	mple					24a. Was	sy	24b. Were a prior to death?	utopsy findings available completion of cause of				
a	r: Th icate r. pag						1 ☐ Yes	rmed? 2100 No		s 2 No				
Ĭ	sicien: The taw s certificate has t lirector, page 2 s	o Be	25. Was case referred to medical examiner?  1 ☐ Yes 25 No Hospital: 1 ☐ Inpatient 2	2 🗋 ER/Outpat	iont 30 DOA Othe	26. Place of Dea								
ō	y Phy ar this eral d	n; To	27. Manner of Death 28a. Date of Injury	28b. Time	of 28c. Injury	4 Minursing H	ome 5 Resident			ecity)				
<u>o</u>	nding ath. r: Afte e fun	atio	1 Xatural 5 ☐ Pending (Month, Day Year 2 ☐ Accident investigation	r) Injun		? ′es 2 ☐ No								
Division of Vital Records,	r Atte er de: recto by th	Certification:	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of Injury · A building, etc. (Sp.	t home, farm,	street, factory, office		28f. Location (S City or Tox	Street and	Number or F	Rural Route Number,				
	itel or its aft rel Di													
	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certifica completely filled in by the funeral director.	Medical	29a. Certifier Lacertifying Physician: To the best of my (Check only one) 2 Medicel Examiner: On the basis of exam	knowledge, de nination and/or	eath occurred at the time investigation, in my op	e, date and place inion, death occu	, and due to the rred at the time,	cause(s) date and	and manner a place, and du	s stated. e to the cause(s)				
	thin 2 the o the	Med	one) and manner stated.  29b. Signature and title of pertifier		29c. License	number		29d. Date	signed (Mor	th, Day, Year)				
	F 3 F 8		1.97 -	10	D:	32600		3	1121	06				
	h		30. Name and address of person who completed cause of death (	Item 23a) (Tyr	e, Print)		1		-	3				
_			Rammedin Milhams	Mp 1	106 Rieva	lulies	Stya	we	Dego	au M321630				
	Sta		31. Date filed (Month, Day, Year) 32 Registrar's Si	gnature	Carles		1							
	Registr	ar	WIAK 1 4 ZUUD A A BOOKER	200	Trees . Charles									

Willbugh Dale

			State of Maryland / Department of Health and  1- State  Certificate of Death	Mental Hy	/giene 006	07697
	Physici	an	Decedent's Name (First_Middle, Last)	2. Date of Di Month	eath Day Year	3. Time of Death
	/Medic Examin	al	Emma C. Waterhouse 44 Facility Namp (If not institution, give street and number) 4b. City, Tpwf, or Location of Dea		4c. County of Dea	8:30 A M
	H	<u> </u>	Gil Christ Hospice Baltimore  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year   If Under 24 Hrs	s. 8. Date of B	irth 9. Bi	nthplace (State or Foreign
	Funeral Director		216-14-7867 1 M 270 F 83 Yrs. Months Days Hours Min	9-7	1922 9. Bi	Country) VA
	yland		Usual Residence of Decedent  10a. State 10b. County 10c Dty, Town or Location			10d. Inside City Limits
	death with the Maryland ms 23a or 28a-1 show Eneral Se notified at	Funeral Director	10e. Streetand Number 10f. Zip Code		10g. Citizen of What C	1 □Yes 2 No
A	ath with 23a or	rai Di	18 Village Mill Court 21117		45	A
36		by Fune	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Never Married 2 Married  11. Was Decedent tof Hispanic Origin? (If Yes, specify Cuban, Mexican, Pue)  11. Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Pue)  12. Was Decedent tof Hispanic Origin? (If Yes, specify Cuban, Mexican, Pue)  13. Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Pue)  14. Was Decedent tof Hispanic Origin? (If Yes, specify Cuban, Mexican, Pue)	Specify Yes or N irto Rican, etc.)	14. Race - Am Black, Wh Specify:	
04 8			3 Wildowed 4 Divorced Year or Dates:  15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of which done during mest of well life. DO NOT lise retired)	orking	16b. Kind of Busines	s/industry
21215	be filed within 72 ho ital Hygiene. Ind other than "natu event, the Medical	Completed	Elementary/according (0-12) College (1-4or 5+) Accounting Ce	rk	Fina	nce
	I be filed ntal Hygi ed other	Be		1.	le, Maiden Sumame)	200
Acou	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any injury or other treumatic event, Ital Ms once.	ပ္	a. Informant's Name/Relationship (y rint) 19b. Mail ddress (Street and Number of F	Rural Apute Num	. II AAN	Zij Code)
= 0	s 1 and 7 Health Item 27 other tr	1	20a. Method of Disposition 20b. Place of Disposition Name of permetery, crematory or other place)	Date/	c. Location - City of	r Town, State
auch II	Pages tment of tant: If It		4 Donation 5 Other (Specify) Lakeview Lemekry 3/	18/06	Sykesvil	le mo
March II,	permit. Departi Import any inj		21. Signature of Funeral Service licentee R728 Liberty Rd	ene Fu . Randa	llstown, M	D 21/33
			23a, Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardinated, or heart failure. List only one cause on each line.  Immediate Cause (Final	ac or respiratory	arrest,	Approximate Interval Between Onset and Death
	Physician /Medical		tmmediate Cause (Final disease or condition resulting in death)  a. LYMPHOCYTIC LEUKEMIA  Due to (or as a consequence of):	Chance	- accereate	Mouth's
	Examiner	Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying  b. Due to (or as a consequence of):			
Sel	icate be executed physicien and s the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):			,
Em Em	cate be e	dicai	d			
Soy 6	death certific	Ψ.	IF FEMALE: 23b. Was decedent pregnant  1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy		23d. Date of d	
200 C	that the death certifications to by the attending of detached for use as	by Physician/M	in the past 12 months?  1 □ Yes 2 No 9 □ Unknown  1 □ Unknown  1 □ Ves 2 No 9 □ Unknown		Month	Day Year
2 4	requires that the		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		d tobacco use contribute  ☐ Yes 2 ☐ No 3 ☐	to the cause of death?
2000	2 sl	Completed		24a. Wa	topsy prior t	autopsy findings available o completion of cause of
Ba	n: The fficate h	e Com	25. Was case referred to medical 26. Place of D	per 1 ☐ Yes	-70	? es 2□ No
5	Physiclan: this certific ral director,	To B	examiner? 1   Yes 2   No	Home 5□Re	sidence Other (S)	pecify) HOSPICE
2	Attending P r death.  sctor: After I by the funera	atlon:	27. Manner of leath 1 Natural 5 Pending 2 Accident investigation 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 8 Injury at Work? 1 Yes 2 No	280. Describ	e how injury occurred	
, doisivio	or Atte after dea Directo	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		(Street and Number or Town, State)	Rural Route Number,
	Hospite 14 hours Funeral tely filled	edical C	29a. Certifier (Check only one)  1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and pla 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	ice, and due to the courred at the time	ne cause(s) and manner e, date and place, and d	as stated. ue to the cause(s)
	To the within 2 To the comple	Med	29b. Signature and title of certifier  29c. License number		29d. Date signed (Md	nth, Day, Year)
	16		39. Name and address of person who completed cause of death (Item 23a) (Type, Print)		05/11/20	HOOP
	[0		Kendall R Favilence MD/6701 N. Charles St	reat/Ba	ecto MD?	71204
	St Regist	ate rar	31. Date filed (Month, Day, Year)  32. Resistrar's Signature			

		-	For State Registrar	State	of Marylan		artment o			nd Men		giene Rog. No.	006	071	598
	Physici	an	1. Decedent's Name (First, Midd	Morris	Earl		Woo	nds			Date of De Month rch		006 Year		of Death 5 a M
1950	/Medic Examin		4a. Facility Name (If not institution				4b. City, Tox		ocation of				County of Deat		
	LXamiii	CI	134 Saddletop	Drive			Taneyt	own				Ca	arroll		
	Funeral		5. Social Security Number	6. Sex 123M 2□F	7. Age (In yrs.	last birthday) Yrs.	If Under 1 \ Months D		Il Under 2 Hours	Min. 8. [ Min. (a Janua	ate of Bir Month, Da	th y, Year)	9. Birti	nplace (Stat untry)	e or Foreign
	Director	}	217-22-6966 Usual Residence of Decedent		79	113.				Janua	ry 3,	192	7 Iow	a	
	yland how		10a. State 10b. County	1	10c. Cit	y, Town or Lo	cation								City Limits
	Ba-f s	Director		roll	7	Caneyto	1								es 2□No
	with th	Dire	10e. Street and Number	D			10f. Zip Co	217	Q 7			-	en of What Co	•	America
	be filed within 72 hours after death with the Maryland at Hygiene.  ad other than "natural", or items 23a or 28a-f show other than "natural", or items 23a or 28a-f show event, the Medical Examinar must be notified at	Funeral	134 Saddletop  11. Marital Status	12. Was De	cedent Ever in U	.S. 13. \	Was Deceden f Yes, specify			in? (Specify			4. Race - Ame	rican Indian	
ထ	or Iter		1 ☐ Never Married XX Mar	rned 1 XYes If Yes, G	2 No		fYes, specify 1 □ Yes 2【X		, Mexican, Specify:	Puerto Rica	n, etc.)		Black, White	hite	
8	Jeal', c	d by	3 Widowed 4 Divorce	Year or	Dates: WW	II									
<u>7</u>	n 72 h	Completed by	(Specify only highe	nt's Education est grade completed		(Give	dent's Usual C kind of work o DO NOT use i	done du	ion iring most	of working		16b. Kind	d of Business/	ndustry	
212	d within	omp	Elementary/Secondary (0-12)	College	(1-4or 5+)	Iron	Worker	:				Local	1 Unior	#16	
g	be filed ital Hygie of other event,	BeC	17. Father's Name (First, Middle,	Last)						r's Name (Fir	-		,		
<u> </u>	2 should be and Menta Is marked sumatic ev	70	Charles Albert						<del>-</del>	y Mari					
Mar	s 1 and 2 should f Health and Mer ltem 27 is marke other traumatic		19a. Informant's Name/Relation Marian T. Wood		(Wife)		ng Address (S Saddlet						Town, State, 2 21787	(ip Code)	9
ore,	000	1	20a. Method of Disposition 1 ☐ Burial 2 🂢 Cremation			Place of Dispo				Date	006		ation - City or		
Baltimore, Maryland 21215-0036	permit. Pag Department Important: I any Injury o		4 Donation 5 Other (3			22	. Name and A	Address	ol Facility	Loring	Bye	rs Fu	neral I	)irect	ors, In
	<b>₹</b> □ <b>= a</b>		23a. Parti. Enter the disease, of	reliner	Mod 33				-				MD 2113	33-478 Approxim	
	Discontinuo.		shock, or heart failure. Lis	t only one cause on	each line.	,				3414140 01 100	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			Interval t Onset ar	Between
	Physician /Medical		disease or condition resulting in death)	a	(or as a conseq		> Co	w	~					<u>-</u>	
	Examiner		Sequentially list conditions	b											
1/	sit ad	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to	o (or as a conseq	uence ol):									
6	be executed icien and burial-transit	Examiner	that initiated events resulting in death) Last	c. Due to	o (or as a conseq	uence of):			_						
760,	ate be executed hysicien and he burial-transit	caiE		d											
9	tificat ng phy as the														
.O. Box	at the death certifica by the attending ph tached for use as th	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live	utcome of pregna birth 2 Feta gnant at time of d nown	ıl death 3 □	Ectopic pregi Other (speci					23	3d. Date of del Month	very Day	Year
Ω.	The law requires that the ste has been signed by th bege 2 should be detache	by Pt	Part II. Other significant condit	ions contributing to	death but not res	sulting in the u	nderlying caus	se giver	n in Part I.		23e. Did 1	tobacco us	e contribute to	the cause	of death?
Records,	w require been sign									-	1)34	Yes 2□	]No 3□Pr	obably 4	□Unknown
ec	e law r has be ge 2 sh	Completed									24a. Was auto	osv	24b. Were au	topsy findin	gs available of cause of
<u>e</u>											1 ☐ Yes	-	death? 1 ☐ Yes	32 No	
Vita	ysician: is certific director,	o Be	25. Was case referred to medical examiner?	Hospital:	Inpatient 2	EB/Outpation	3 DOA	Other		of Death (Ch	1		☐Other (Spe	2,641	
ō	문 = 교	n: To	27. Manner of Death	28a. Date	e of Injury	28b. Time of		. Injury :	4 🗆 1401			how injury		city)	
<u></u>	tending F death. tor: After the funer	atio		tigation	nth, Day Year)	Injury	М		es 2 🗆 N	No					
Division of	or Attandation death Director:	Certification:	3  Suicide 6 Could deten	mined 288. Place	e of Injury - At h	ome, farm, str fy)	eet, factory, o	office				Street and wn, State)	Number or Ru	iral Route N	umber,
	To the Hospitel or At within 24 hours after of To the Funeral Direct completely filled in by		29a. Certifier Certify	ing Physician: To the	ne best of my kno	owledge, deat	n occurred at	the time	e, date and	d place, and	due to the	cause(s) a	and manner as	stated.	
	the Ho in 24 I the Fu ipletel	Medical	one)		basis of examina nner stated.	ation and/or in				th occurred a	t the time,				
)	To the I within 2 To the Complet	2	29b. Signature and title of certification in the second se	er Lta	~ m	2			L ア い	1 3			signed (Mont	h, Day, Yea	r)
	3		30. Name and address of person			m 23a) (Type,	Print)			S D	*	А	10/06 lt m	4	
	Sta	to.	31. Date filed (Month, Pay, Year	Thompo	Registrar's Signa	ature		<u> </u>	0	J 1	7	120	er m	)	
4	Registi		MARI	4 2006	Mine 1	St A	all!								
DH	MH 17 Rev 1/2	001				-									

			i icasc	State of Maryland			-	_	0 m d d G
		•	1 - For State Registrar	Otate of Marytana	•	te of Death		Z U U 6	07699
			Decedent's Name (First, Middle, La	ist)			2. Date of Death Month	Day Year	3. Time of Death
	Physici /Medic		P. ELAINE	WILLS			mont	12 2016	1:15 PM
	Examin		4a. Facility Name (If not institution, give	//	1	, Town, or Location of Death		4c. County of Deat	h
				WOOD KD		EL AIR		Harfer	
	Funeral Director			Sex 7. Age (In yrs. la	Yrs. Months	r 1 Year If Under 24 Hrs. Days Hours Min.	8. Date of Birth (Month_Day.)	early I Co	hplace (State or Foreign aryland
	pu s		Usual Residence of Decedent  10a. State 10b. County	10c, City	Town or Location				10d. Inside City Limits
	e Maryla Ba-f sho	ctor	mo Har	tord Be	elAir				1   Yes 2 1 No
	th with the 23a or 2	Funeral Director	109. Street and Number	ood Rd.	10f. Z	21014	100	g. Citizen of What Co	ountry?
980	within 72 hours after death with the Maryland ane. then "natural", or itams 23a or 28a-f show in Madical Examinar must be notified at	þ	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever in U.S Armed Forces 1 Tyes 2 Mo If Yes, Give Year or Dates:	3. Was Dec If Yes, sp 1 ☐ Yes	edent of Hispanic Origin? (Specify Cuban, Mexican, Puerto 22 No Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White Specify: W	
21215-0036	be filed within 72 hours ital Hygiene. Id other then "natural; event, the Medical Ex-	Completed	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12)	ducation rade completed)  College (1-4 or 5+)	16a. Decedent's Us (Give kind of w life. DO NOT	ork done during most of work		6b. Kind of Business/	Industry
21	filed with Hygiene other the	Com	Listing its property (c. 12)	NIA	Hoi	nemaker		at.	Home
p	be filed tal Hygid d other	Be	17. Father's Name (First, Middle, Las.			18. Mother's Nam	e (First, Middle, Ma I A	aiden Sumame)	
<u></u> ₹	should be and Mental marked o	<sup>2</sup>	Arthur	Brenale		Pear	1 And	drews	7-0-1-1
Maryland	12 sho h and 7 is mu treum		19a. Informant's Name/Relationship	(Type, Print)	19b. Mailing Addres	s (Street and Number or Rui	al Houte Number,	A C MA	) / ( / ( /
	s 1 and 2 should I Health and Men item 27 is marke other treumatic		20a, Method of Disposition	20b. Pla	ace of Disposition (N	ame of	Date 20	Dc. Location - City or	Town, State
Baltimore,	e = 5		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special Control of Cont	_Hemoval from State	metery, crematory or	other place)	14/N-1	Forest 1	till ma
Ħ	artu artu	1	21. Signature of Funeral Service Lice			and Address   Facility =	ans Fun	end chair	el of memories
æ	Per Per Per Per Per Per Per Per Per Per		16/20.6	111	91	le uiPort E	or Fores	st Itill m	101000
			23a. Part1. Enter the disease, or con shock, or heart failure. List only	nplications that caused the death.	. Do not enter the mo	de of dying, such as cardiac	or respiratory arres		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	- 1	ahon'				Onset and Death
	/Medical		resulting in death)	Due to (or as a consequence					
в	Examiner		Sequentially list conditions,	b. Dysoha	61~				day
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ū	ding Physician: The I h. After this certificete ha funeral director, page		27. Manner of Death 1 ☐Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how	v injury occurred	
Sio	tend death tor: /	cat	2 Accident investigation 3 Suicide 6 Could not	ha .	M	1 Yes 2 No	29f Location /Str	eet and Number or R	ural Pouta Number
Division	al or A	Certification:	4 ☐ Homicide determine	28e. Place of Injury - At hor building, etc. (Specify,	nie, iaim, stieet, iacti	ry, once	City or Town,		urai Hobie Naliber,
	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the fune	Medical C	29a. Certifier 1 Certifying P (Check only one) 1 Medical Exa	Physician: To the best of my know aminer: On the basis of examinati and manner stated.	wledge, death occurre tion and/or investigation	d at the time, date and place on, in my opinion, death occur	and due to the cau	use(s) and manner a te and place, and du	s stated. e to the cause(s)
	To th withir To th compl	Me	29b. Signature and title of certifier		1 -	9c. License number		d. Date signed (Mon	
	/		Wend K	les		D31295		3/13/00	, o
	6	1	30. Name and address person who wench Klotsz		23a) (Type, Print)	D31295	Surta >6	SA BO	nd red 2/33
	Sta Regist	ate rar	31. Date filed (Month, Day, Year)	32. Registrar's Signat		- Triples			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygierie U 5 Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year 8:23 PM WALTERS Month **Physician** JOHN Ē MARCH 2006 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner HOSPITAL BALTIMORE CITY HARBOR If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 8 irthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Sex 1 M 2 □ F **Funeral** Months Days Hours Yrs. 7-3-1919 MD 216-01-9404 **Director** Usual Residence of Decedent 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location 28a-f show th and Mental Hygiene. 27 is marked other then "netural", or Items 23s or 28s-f shov traumstic event, the Nedical Examinar must be notified at 1 Tyes 2 X No Director Anne Arundel Glen Burnie 10a. Citizen of What Country? 10e. Street and Number 21060 308 Blue Water Court, Unit 202 U.S.A. Completed by Funeral 14. Race - American Indian, 8lack, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? permit. Pages 1 and 2 should be filed within 72 hours after t Department of Health and Mental Hygiene. Important: If Item 27 Is marked other then "netural", or Item any Injury or other traumatic event, the Mudical Examinations once 1X∑Yes 2 No ff Yes, Give Year or Dates: 1 Never Married 2 Marned white 1 ☐ Yes 2 ☐ No Specify: Specify: Baltimore, Maryland 21215-0036 3X Widowed 4 ☐ Divorced 16b. Kind of 8usiness/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Efementary/Secondary (0-12) United States Gov't Technician 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Katie Sigwart John L.H. Walters 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. fnformant's Name/Relationship (Type, Print) Mr. Donald Lybrook / nephew 5070 Stonehill Drive; Ellicott City, MD 21043 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 

Burial 2 □ Cremation 3 □ Removal from State Glen Haven Memorial Pk 3-11-2006 Donation 5 Other (Specify) Glen Burnie, MD 22. Name and Address of Facility Singleton Funeral Home, PA ture of Funeral Service Litensee 1 Second Ave SW; Glen Burnie, MD 21061 23a. Part1. Enter the disease, or complications that caused the death Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval 8etween Onset and Death Immediate Cause (Final DAYS **Physician** ISCHAEMIC HEPATITIS disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** HEMORRHAGE DAYS GASTRO INTESTINAL Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine DAYS physician and s the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed INFARCTION MYOCARDIAL that initiated events resulting in death) Last Due to (or as a consequence of): YEARS Box 68760 DISEASE CORONARY Physician/Medicai attending pl IF FEMALE 23c. ff yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of defivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4□Pregnant at time of death 5 Other (specify) P.0. 1 Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records. þ 1 Yes 2 No 3 Probably 4 Unknown HYPERTENSION Completed 24b. Were autopsy findings available prior to completion of cause of death? MELLITUS 24a. Was an DIABETES autopsy performed 1 ☐ Yes 2 ☐ No HEART FAILURE 1□ Yes CONGESTIVE Division of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA ၉ 28a Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 27. Manner of Death Certification: 1 Natural 5 Pending investigation 1 Tes 2 No after death. Director: Af 2 Accident filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after or To the Funeral Direct completely filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year)
MARCH 7, 2006 29c. License number 29b. Signature and title of certifier 000 RES MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MALA SIVANANDY 3001 S HE HANOVER STREET, BALTIMORE, MD 21225 SIVANANDY 3001 MALA 31. Date filed (Month Day, Year) MAR 1 4 2006 32. Registrar's Signature State 19000 Registrar

Physicia /Medic Examin		Registrar Amend Item	#8 Per FH G853	3/28	NO GCAJH of	Death		Reg. No.	Ub	0//(
/Medic		1. Decedent's Name (First, Middle, Last	)				2. Date of De Month	ath Day	Year	3. Time of D
		Beatrice L.,	Williams				March		2006	1720
		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, o	r Location of D	eath	4c. Cou	inty of Death	h
		Suburban Hospi			Betheso			Mont	gome	
Funeral		5. Social Security Number 6. Se	7. Age (In yrs. las	st birthday) Yrs.	If Under 1 Year Months Days		vin. (Month, Da	th 1928	9. Birth	hplace (State or a untry)
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d B	ğ	MD	D	1	7					1 ☐ Yes 2
28a	rec	MD Montgome  10e. Street and Number	<u>ry Koc</u>	kvil	10f. Zip Code			10g. Citizen	of What Cor	untry?
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ene. than "natural" or items 23e or 28e-f show he Madical Exeminer must be indiffed at	Funeral Director	11. Marital Status	12. Was Decedent Ever in U.S.	13.			? (Specify Yes or No uerto Rican, etc.)	UŞA - 14. İ		ncan Indian,
or te	Ī	1 Never Married 2 Married	Amed Forces? 1 ☐ Yes ♀∇No If Yes, Give		1 ∐ Yes 2 No		uerto Rican, etc.)		Black, White	•
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natu	Completed	15. Decedent's Edu (Specify only highest grad	ucation le completed)	16a. Deced	dent's Usual Occup	ation during most of	working	16b. Kind o	f Business/I	Industry
iene. r than "n the Madi	du	Elementary/Secondary (0-12)	College (1-4or 5+)	`life. I	DO NOT use retired	d)		Cit	y of	St.
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Men	٩	Frank Lodkey				Eliz	zia Lodk	еу		
th and Men 7 is marke treumatic		19a. Informant's Name/Relationship (7)					r Rural Route Numbe			
Item 27 other tr		Gary T. William		5808	Rollin	g Driv	ze, Rock	ville	, MD	20855
5 2 5		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ I	Removal from State	netery, cren	sition (Name of matory or other plac	ce)	Date	20c. Location	on - City or I	rown, State
tant:		4 ☐ Donation 5 ☐ Other (Specify)	Cro	wnsv	ille Ve	t. 3-	-14-04	Crow	svil	le. M
Department Important: If any Injury o		21. Signature of Funeral Survice Licens		_ 22	2. Name and Addre	ss of Facility V	Vylie F/I	H PA	of Ba	alto.Co
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		23a. Pari1. Enter the disease, or comp shock, or heart failure. List only o	lications that caused the death. ne cause on each line.	Do not ent	er the mode of dyir	ng, such as car	diac or respiratory a	rrest,		Approximate Interval Between
ysician		Immediate Cause (Final disease or condition	Breast Ca	ncer						Onset and De
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i d	٠ <u>. ۲</u>	1 ☐ Yes 2 No ☐ 27. Manner of Death	1 Inpatient 2 E	VOutpatien 8b. Time of	I SELECT	4 1401211	g Home 5 Resident			uty)
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프	O	29a. Certifying Phy	sician: To the best of my knowle	adae death	accurred at the tie	no data and o	lace, and due to the	cours/a) and		ateta d
filled in t	Ö	(Check only 2   Medical Exami	iner: On the basis of examination and manner stated.	n and/or inv	vestigation, in my o	pinion, death o	eccurred at the time.	date and plac	e, and due	to the cause(s)
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ine in in	Medi	29b. Signature and title of certifier  Muchael a. h  30. Name and address of person who ce		За) (Туре,	D524	51		March	9, 2	2006

			For State Registrar	State of M		d / Depa	artment of H	lealth and	Mental Hy	giene Reg. Nő.	006	07703
7	Physici		Decedent's Name (First, Midd     SEYMOUR	fle, Last)		la/ F	INBERGER		2. Date of De Month MARCH	Day	2006	3. Time of Death 8:45 A M
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\$ 100 mg	Director		065-10-1026	1 <b>X</b> M 2□ F	89	Yrs.	Months Days	Hours Mil	s. 8. Date of Bir (Month, Da JAN. 16	,1917		NY
	and and		Usual Residence of Decedent  10a. State 10b. Count	у	10c. Cit	y, Town or Lo	ocation					10d. Inside City Limits
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	ems ems	Funerai	11. Marital Status	12. Was Deceden Armed Forces	i?	.S. 13.	Was Decedent of H	lispanic Origin? ( an, Mexican, Pue	Specify Yes or No erto Rican, etc.)	- 14	Race - Ame Black, White	
36	or It	y Fu	1 Never Married 2 Ma	rried 1 X Yes 2	] No	1	1 ☐ Yes 2 💢 No				pecify:	WHITE
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-7R.	402 4 4	Н	23a. Part1. Enter the disease,	or complications that cause	ad the deat		00 REIST				ORE, M	Approximate
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99	The law requires that the death certificat are been signed by the attending phy page 2 should be detached for use as the	Med	IF FEMALE:									
Box	th ce tendi	an/I	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcom 1 ☐ Live birth	2 Feta	al death 3[	⊒Ectopic pregnanc	:y		23	d. Date of de	livery Day Year
	e dea the at hed fo	Physician/M	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant 9□Unknown		death 5	Other (specify)					,
P.0	that the de led by the a detached b		Part II. Other significant condi	tions contributing to death	but not res	sulting in the s	inderlying cause g	ven in Part I.	23e. Did	tobacco use	contribute to	o the cause of death?
Ś	signe	by		•	. Dut not not	January III III II	arradiny ing daddo gi	V 311 111 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	1 🗆	Yes 2 🗗	No 3 □ P	robably 4 Unknown
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Vital	Physician: The this certificate hiral director, page	o Be	25. Was case referred to medic examiner?  1 Yes 2 No	Hospital: 1 ☐ Inpa	ationt 2	] ER/Outpatie	ent 3□ DOA Ot	hon	eath <i>(Check only</i> Home 5 - Res		Other (Sne	acifu)
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	$\nu_{\mathbb{D}_{ imes}}$	1	30. Name and address of person	on who completed cause of	of death (Ite	m 23a) (Type	, Print)	A .	town,	-   -		
	10		JULL Asin	Kove 750	MA	2 ~	1	Ke 1 stars	town	m.)	21,36	
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Ž.	Regist	rar	MAK I	4 4 4 4 4 4 4	ear .	K A	marke 8					

		1 - For State Registrar		Ota	te or ivid		artment of F			g. No.2 0 0 6	07704
Physici	an	1. Decedent's	Name (First, Middle	-		1	LUITTMAN		2. Date of Deat	0, Day 2006 Yea	3. Time of Death
/Medio		4a. Facility Na	CHASE		nd number)	L.	WHITMAN 4b. City, Town, o	r Location of Death	<del></del>	4c. County of De	2.30 A
LXUIIII	101	STEL	LA MARIS	HOSPIC				TIMONIU	IM		BALTIMORE
Funeral Director			2-5526	6. Sex 1 M 2		e (In yrs. last birthday 79 Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth Month Day, MAY 5,	1926	inthplace (State or Foreigr Country) MD
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7.28a-f	recto	MD 10e. Street and		/A	-	DAL	10f. Zip Code	_	10	0g. Citizen of What (	
23e or	ai Di	3801	CANTERBUR	Y ROAD	#914	•		21218			USA
or Its	by Funeral Director		tus Married 2 <b>X</b> Marr red 4 □ Divorced	ied 1   If Y	s Decedent ned Forces? ]Yes 2 XI es, Give ar or Dates:		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	tispanic Origin? (Sp an, Mexican, Puerto Specity:	ecify Yes or No- Rican, etc.)	14. Race - Ar Black, Wi Specify:	n <i>e</i> rican Indian, nite, etc. WHITE
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Amend Item 29c per verbal, G853 03/24606dbeath 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** ESSIE 1440 52006 /Medical 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner Medica Baltimore Baltimore Cit Mercy If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) 1/21/1921 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Days 227 20 8106 Usuel Residence of Decedent Months Hours Min. 12 M 2 F 85 Yrs Director Va. 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State Y□Yes 2□No Md. NA Baltimore Direct 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 2556 Robb Street Funeral 21218 USA 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married
3 Widowed 4 Divorced 1 ☐ Yes 2 ☑ No If Yes, Give X Year or Dates: 1 ☐ Yes 2 No Specify. by Specify: Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Truck Driver Seltest Milk 5th grade 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be David Walton Henrietta Vauqhn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Fannie Walton Daughter 2556 Robb Street , Baltimore, Md. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Department of P Important: If its any injury or of once. 1 ☑Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) King Mem. Pk. 3-11-06 Randallstown, Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Baltimore, Md. 21202 March F.H. East 1101 E. North Ave. 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Intervat Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Stant Staphylococcus Aureus Bacterenia Methacillin Res. Due to (or as a consequence of) g Stag Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Dav 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρŞ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 No 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death | Check only one Be 1 ☐ Yes 2 ☑ No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 \_\_npatient 2 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 Naturai 1 ☐ Yes 2 ☐ No M 2 Accident 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Thomicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and she to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one)

The law requires that the death certificate be executed and the attending physician a hed for use as the burial-P.O. Box 68760. been signed by the should be detached Records, certificate Division of Vital To the Hospital or Attending Physicien: this Director: After this in by the funeral of death. within 24 hours after death To the Funerel Director: completely filled in by the

**Funeral** 

Items 23s or 28s-f show

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natural

the Medical Examiner must be notified at

with the Maryland

death

filed within 72 hours after

Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. Int: If itam 27 Is marked other than

permit.

**Physician** /Medical

Examiner

Baltimore, Maryland 21215-0036

State

DHMH 17 Rev 1/2001

Registrar

Sapko Michael 31. Date filed (Month, Day, Year) 32. Registrar's Signature MAR 1 4 2006

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SAPRO

29b. Signature and title of certifie

29c. License number P19823

29d. Date signed (Month, Day, Year)

St. Paul Place, Bultimore MD 21202

March 6,2006

		-	For State Registrar	State of Maryla		artment of Heatificate of De			ene 2006	07706
	<b>.</b>		Decedent's Name (First, Middle, La	st)				2. Date of Death		3. Time of Death
	Physicia /Medic	al .	BETTYE GARDNEF					March 11		7:30 р. м
	Examin	er	4a. Facility Name (If not institution, giver 409 Brightwood (			4b. City, Town, or Lo Luthervi			4c. County of Death Baltimore	
	Funeral		5. Social Security Number 6. S	Sex 7. Age (In y	rs. last birthday)	If Under 1 Year		8. Date of Birth	9. Birtl	nplace (State or Foreign
	Director		214-46-8975	□ <sup>M</sup> <sup>2</sup> X <sup>F</sup> 91	Yrs.	Months Days	Hours Min.	8. Date of Birth Month, Day NOV • 30	1914 CAN	ABA
	and		Usual Residence of Decedent  10a. State 10b. County	10c.	City, Town or La	cation				10d. Inside City Limits
	Maryl	to	Maryland Baltimor	·e .	Luthervi	11e				1 ☐ Yes 2 ☐ No
	th the	Director	10e. Street and Number		<u> Labrici ( 1</u>	10f. Zip Code		100	g. Citizen of What Co	untry?
	ath wi	raiD	409 Brightwood			21093			U.S.A.	
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or Items 23a or 28a-f show he Medical Esserill or maist be multis of a	by Funeral	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☐ X Vidowed 4 ☐ Divorced	12. Was Decedent Ever in Armed Forces?  1		Was Decedent of Hisp f Yes, specify Cuban, 1 □ Yes 2 ☼No	anic Origin? (Spec Mexican, Puerto R Specify:	offy Yes or No- Rican, etc.)	14. Race - Ame Black, White Specify: Wh	e, etc.
5	72 ho natur	eted	15. Decedent's E (Specify only highest gr	ducation ade completed)	(Give	dent's Usual Occupation	on ing most of workin	16	6b. Kind of Business/	Industry
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Baltimore,	permit. Pages Department of I Important: If Ite any Injury or o'		1 ☐ Burial 2 ☐ Cremation 3 ☐  4 ☐ Donation 5 ☐ Other (Speci	_Hemoval from State		sition (Name of natory or other place) int Cremato	ory <b>3/13</b>		altimore,	
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)	To the To the	M	29b. Signature and title of certifier	Queott	MI	29c. License r	50414	290	3/13/0	h, Day, Year)
1	20		30. Name and address of person who	completed cause of death	(Item 23a) (Type. 55 Fol	Print) (15 Ro , C	u trenvil	le mo	21093	
	Sta Registi	. • <i>. 5</i>	31. Date filed (Month, Day, Year) MAR 1 4 20	and manner stated.  Out off completed cause of death COTT 107	ignature /po	de)				

			1 ~ For State Registrar	State of Mar	yland / Depa		Death	ental Hyg	100 0 6	07707	
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	hours after death with the Maryland tural', or Items 23e or 28e-f show al Examiner must be notified at	ector	Usual Residence of Decedent  10a. State 10b. County  Maryland Anne Art  10e. Street and Number		oc. City, Town or Lo Pasadena					10d. Inside City Limits 1 ☐ Yes 200 No	
	eath with t	Funeral Director	644 Laurel Drive	12. Was Decedent Evo	er in II S	10f. Zip Code	21122		10g. Citizen of What Country?  USA  No- 14. Race - American Indian,		
9036	72 hours after death with the Marylan natural', or Items 23e or 28e-f show dical Examinet must be notified at	Þ	1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced	Armed Forces?  1  Yes 2 No If Yes, Give Year or Dates:		f Yes, specify Cuba 1 ☐ Yes 2 ⊠ No	ispanic Origin? (Spe n, Mexican, Puerto F Specify:	Rican, etc.)	Saariba		
21215-0036	within 72 ene. than "na	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)	College (1-4or 5+)	(Give	dent's Usual Occupa kind of work done o DO NOT use retired Clerk	luring most of workin		16b. Kind of Business/ Reeds Drug		
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Ω	To the Hospitel or Atte within 24 hours after de To the Funeral Diracto completely filled in by th	Medical Cer	29a. Certifier (Check only one)  1	vsicien: To the best of iner: On the basis of ex	camination and/or in-	n occurred at the time	ne, date and place, a pinion, death occurre	nd due to the c	ause(s) and manner as late and place, and due	stated. to the cause(s)	
	To the I within 2. To the I complet	Med	29b. Signature and title of certifier	and manner state	o.	29c. License			29d. Date signed (Month		
Transport of	7		30. Name and address of person who	ompleted cause of dea	th (Item 23a) (Type,	Print)	7,11-11e	Rd	Bowler	√2006	
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's	Signature	(h)					

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registre Certificate of Death Reg. No: 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year February 24, 2006 9:28 **Physician** Barbara Ann Aston рм /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Washington Adventist Hospital Takoma Park Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
Months Days Hours Min. (Month, Day, Year)
May 17, 19 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 9. Birthplace (State or Foreign **Funeral** Months 1 □ M 2 🖾 F 577-54-4985 Yrs. Director 65 1940 Washington, Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County in then "naturel", or Items 23a or 28a-f show the Medical Examinar must be codified at 1X Yes 2 □ No Directo Maryland Prince George's New Carrollton 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code with 6427 Fairbanks Street 20784 USA Funeral Pages 1 and 2 should be filed within 72 hours after deeth ment of Health and Mental Hygiene. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify:White 1 ☐ Yes 20 No Specify: þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Owm Home alth and Mental Hygier 27 is marked other tin traumatic event, in 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Otho Muncaster Mullineaux Marie Elizabeth Tassa 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) C epartment of Health a Important: If Item 27 Is any Injury or other tra Robert W. Aston/ Husband 6427 Fairbanks Street, New Carrollton, MD 20784 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State March,1, 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Fort Lincoln Cemetery 2006 Brentwood, Maryland 4 □ Donation 5 □ Other (Specify) 22. Name, and Address of Facility
Francis J. Collins Funeral Home Inc
500 University Blvd, W, Silver Spring, ND 20901 nter the c sease, or complications that cous or heart ure. List only one cause on each Approximate Interval Between Onset and Death the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Physician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed sicien and burial-trans Due to (or as a consequence of): physicien a Box 68760. Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Day 4 Pregnant at time of death 5 Other (specify) P.O. 1 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. þ 1 | Yes 2 | No 3 | Probably 4 DUNKnown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed Hypertension Division of Vital 1 ☐ Yes 2 D No Hospital or Attending Physician: director, 25. Was case Be 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 □1100 Certification; To 2 ER/Outpatient 3 DOA T S 28a. Date of Injury (Month, Day Year) After thi 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number. City or Town, State) 4 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and titte of certifier 29c. License number 00046518 address of person who completed cause of death (Item 23a) (Type, Print) Good 31. Date filed (Month, Day, Year) 32. Registrar's Signature State FEB 28 2006

Registrar

13	25			Please	Type or Prin						-	_	le.		
			For State Registrar		State of Ma	arylan		rtificate of		h	Re	g. No. U	6	077	09
	Physici /Medic		1. Decedent's Name Juan J	o (First, Middle, Las Jose Alf							oate of Death Month Druary		ŎÖ6	3. Time of 1018	
	Examin		4a. Facility Name (h		e street and number)			4b. City, Town, 6		n of Death		4c. County o		rge's	
	Funeral Director		5. Social Security N 226-97-56	502	Sex 7.Ag		last birthday) 0 Yrs.	If Under 1 Year Months Days		er 24 Hrs. 8. D Min. (/	Date of Birth Month, Day, 7 • 10 ,	Year) 1965	Coun	lace (State try) entin	-
	Maryland f show	or	Usual Residence of 10a. State	10b. County			y, Town or Lo	cation					1	0d. Inside C	City Limits
	vith the	Direct	Virginia  10e. Street and Nur		.1	реа	recon	10f. Zip Code 22712				0g. Citizen of Wi		ntry?	
36	s after death v	Armed R. 1   Never Married A. Married   Armed R. 1   Yes					Decedent Ever in U.S. and Forces?  Yes 2 N No			Vas Decedent of Hispanic Origin? (Specify Yes or No- Yes, specify Cuban, Mexican, Puerto Rican, etc.)  X Yes 2□ No Specify: Argentinian			Black, White, etc.		
2-00	72 hours patural', licel Ex	ted b		15. Decedent's Edify only highest gra			16a. Dece	dent's Usual Occu kind of work done	pation		11an	16b. Kind of Bus	Whi		
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Maryland 21215-0036	be filed ta! Hygi d other event, I	Be Co	17. Father's Name		)		11100				st, Middle, M	Maiden Sumame			
aryla	should nd Men marke umatic	ဥ	Pino Alfo		Type, Print)		19b. Mailir	ng Address (Stree		na Diosn			tate, Zip	Code)	
e, M	l and 2 tealth a mm 27 is		Grace Bro			20h F	_	Cloverme	adow	Dr., Vi	_	Va. 22		own State	
more	Pages 1				Removal from State	.   '	cemetery, crei	natory or other pla Cemetery	. ,	Feb. 2	28	idland,			
Baltimore,	permit. Depertm importe any inju		21. Signature of Fu	neral Service Mcer	nsee			Name and Addu ney & Ki	-	üneral I			00		
	_		23a. Part I. Enter the shock, or hea	ne disease, or com rt failure. List only	plications that cause one cause on each li	d the deat		1 W. Map er the mode of dy					BU	Approxima Interval Be Onset and	etween
7	Physician /Medical Examiner		Immediate Cause disease or condition resulting in death)	(Final on	a. Mul Due to (or as	a conse	uence of):	Tuze	NU	20					
60,	be executed sicien and burial-transit	al Examiner	Sequentially list co if any, leading to in cause. Enter Unde Cause (Disease or that initiated events resulting in death) in	orlying injury	c. Due to (or as						-				
.O. Box 687	ne death certificate the ettending phy-	Physician/Medic	IF FEMALE: 23b. Was deceden in the past 12 1 ☐ Yes 2 [ 9 ☐ Unknown	months? □No	23c. If yes, outcome 1 Live birth 4 Pregnant a	2 Feta	aldeath 3□	□Ectopic pregnanc □ Other (specify) _	ey .			23d. Date Mon		ery Day	Year
<u>α</u>	9 G 9	ρ	Part II. Other signif	ficant conditions	contributing to death t	out not res	sulting in the u	nderlying cause g	ven in Pai	tl.		oacco use contri		ne cause of	
Records,	The e h	Completed									24a. Whas a autops perform	y pr ned? de	ere auto ior to co eath? Yes	psy findings impletion of 2 No	s available cause of
Vital	Physician: 1 this certificel ral director, p	Be	25. Was case refer examiner?		Hospital:			- 10	her	ice of Death (Ch					
ŏ	ding Phys .r After this funeral di	ation: To	1 ☐ Yes 2 ☐  27. Manner of Deat 1 ☐ Natural 2 ☐ Accident		28a. Date of Inju	ury ay Year)	28b. Time of Injury	f 28c. Inju	4 🗀	. 06		winjury occurre		nstructurash	e tor
Division	5 th 15 c	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	DO Diego of in	jury - At h	ome, farm, st	reet, factory, office	port			reet and Number, State) 330			
	To the Hospitei within 24 hours a To the Funerel I completely filled	edicai (	29a. Certifier (Check only one)		hysician: To the best miner: On the basis of and manner st	of examina									(s)
	To the within To the comple	Me	29b. Signature and	tyle of certifie	11.	M	1	29c. Licen		er .	1	9d. Date signed			<i>-</i>
)	12	3	30. Name and addi	ress of person who	completed cause of	dath (Ite	m 23a) (Type,	Print)	ME		F	ebruary			
	Sta	ate	31. Date filed (Mor	Mark of a company	32. Regist	rar's Sign	ature	111 Pe	enn S	treet ]	Baltim	nore, Ma	ry1a	na 21	201
3	Regist	rar		18 28 20	106 Januar	1 10	1	300							

riease Type or Print in Black indelible ink. Ensure All Copies Are Leg			
State of Maryland / Department of Health and Mental Hygiene	16	0771	
Certificate of Death Reg. No.	JU	0///	

	For State Registrar	State of Maryland		tificate of De		Re	g. No.	) U////	
sician	Decedent's Name (First, Middle, Las			D 1		2. Date of Death Month	Day Y	3. Time of Death	
edical miner	Gary  4a. Facility Name (If not institution, give	Delano		Burcker  4b. City, Town, or Lo	cation of Death	March (	06, 2006 4c. County of		
ral	8808 Milwaukee La 5. Social Security Number 6. Se	ane ox 7. Age (In yrs. la	st birthday)	Williamsp	ort I Under 24 Hrs.	8. Date of Birth (Month, Day,	Washin		
tor	219-04-4393	X <sup>M 2□ F</sup> 44	Yrs.	Months Days	Hours Min.	March 4,	1962 N	Maryland	
Be Completed by Funeral Director	Usual Residence of Decedent  10a. State 10b. County	10c. City	Town or Lo	cation				10d. Inside City Limits	
ō	MD Washingt							1 ☐ Yes 2√2 No	
rect	10e. Street and Number	OII WII.	Liamsp	10f. Zip Code		10	10g. Citizen of What Country?		
	8808 Milwaukee La	ne		21795			U.S.A.	•	
by Funeral Director	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:	1	Vas Decedent of Hispa f Yes, specify Cuban,	anic Origin? (Spe Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Black,	American Indian, White, etc. White	
Completed	15. Decedent's Ed (Specify only highest grad	ucation	16a. Dece	adent's Usual Occupation a kind of work done during most of working DO NOT use retired)			6b. Kind of Busin	ness/Industry	
nple	Elementary/Secondary (0-12)	College (1-4or 5+)			uring most of working				
. 3	12		Glass	Cutter				ng Service	
To Be	17. Father's Name (First, Middle, Last) Franklin D.R. Bur	cker		18		e (First, Middle, M ee Fritz			
10	19a. Informant's Name/Relationship (7		10h 14=101-	a Address /Ct				ata Zia Cadal	
				Md 1			•		
	Sherry M. Burcker 20a. Method of Disposition			Milwaukee sition (Name of natory or other place)			OCC, MD	21795 ty or Town, State	
	1   Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify	Removal hom State			2/10	/2006 1	II.	, MD	
ei l	21. Signature of Funeral Service Licen			n Cemetery  Name and Address			Hagersto	Chapal	
	> S. Mark S.	m		01 Pennsyl					
ı I	23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	a	ardic	megaly				Approximate Interval Between Onset and Death	
Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b							
Aedical Ex	leading in death) Last	d	Due to (or as a consequence of):						
Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregnar 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de 9 □ Unknown	death 3	Ectopic pregnancy Other (specify)			23d. Date of Month	of delivery Day Year	
À	Part II. Other significant conditions or	ontributing to death but not resu	lting in the u	nderlying cause given	in Part I.		1	Ite to the cause of death?  Probably 4 □Unknown	
Completed						24a. Was an autopsy	24b. Wei	re autopsy findings available ir to completion of cause of	
Be	25. Was case referred to medical examiner?					Check only one	) 1	0	
ုင	1 EX 163 2 140	Hospital: 1 ☐ Inpatient 2 ☐ E			4 LI Nui sing no	me 5 ☐ Resider		isp scene	
Certification:	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	(Month, Day Year)	28b. Time o Injury	Work?	s 2□No	28d. Describe ho	w injury occurred		
Certification	4 Homicide determined	28e. Place of Injury - At hor building, etc. (Specify,	me, farm, str	eet, factory, office		28f. Location (Str. City or Town,	eet and Number , State)	or Rural Route Number,	
Medicai Cer	29a. Certifier 1 Certifying Ph	ysician. To the best of my know liner: On the basis of examinati and manner stated.	Medgie, daat on and/or in	Sonumed at the time vestigation, in my opin	date and place, ion, death occurr	and due to the ca red at the time, da	uea(e) and mann te and place, and	or as stated. I due to the cause(s)	
M	29b. Signature and title of certifier	dhall. mis		29c. License n			d. Date signed (for the signed) (for the signed) described (for the signed)	Month, Day, Year) 2006	
	30. Name and address of p rson who of	completed cause of death (Item	23a) (Type,	•	n Stree	t Balti	more Mar	ryland 21201	

State Registrar

31. Date filed (Month, Day, Year)

MAR 1 4 2006

Security 15

			. For	State of Man				•	9	ole.	
_			1 - State Registrar		Ce	rtificate of	Death		leg. No.	6.0	7712
J	Physici	an	1. Decedent's Name (First, Middle, La					2. Date of Dea Month	Day	Year 1	Time of Death
	/Medic	cal	Stella L. Bright  4a. Facility Name (If not institution, given			4h Cihi Tours	or Location of Deatl	Februar	4c. County of	000	1:30 A M
-1	Examir	ner	3701 Internationa		1	Silver		1	Montg		
	Funeral		5. Social Security Number 6. S	Sex 7. Age (1.	n yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	1	9. Birtholace	(State or Foreign
Ġ.ĸ	Director		373 20 0723	I □ M 2 💢 F	85 Yrs.	Months Days	Hours Min.	July 9	1920	Virgin	ia
	and w		Usual Residence of Decedent  10a. State 10b. County	11	Oc. City, Town or Lo	ocation				10d. li	nside City Limits
	Marytan -f ehow lied at	to	Maryland Montgom	erv	Silver Sp	ring					X Yes 2 No
	r 28a	rec	10e. Street and Number	CLY	DIIVCI DE	10f. Zip Code			10g. Citizen of W	hat Country?	
	within 72 hours after death with the Maryland ane. then "natural", or iteme 23a or 28a-f ehow 's Medical Exa older mat Le notified at	Completed by Funeral Director	3701 Internation	al Drive #7	31	2090	16		United	States	
	teme	Jue	11. Marital Status	12. Was Decedent Eve Armed Forces?	er in U.S. 13.	Was Decedent of If Yes, specify Cut	Hispanic Origin? (S ban, Mexican, Puert	pecify Yes or No- o Rican, etc.)	14. Race Black	- American Ir	idian,
36	rs afte	γFI	1 ☐ Never Married 2 ☐ Married  3 ☑ Widowed 4 ☐ Divorced	1 Yes 2 No If Yes, Give Year or Dates:	1	1 ☐ Yes 2X No				can Am	
21215-0036	2 hou	edk	15. Decedent's E	ducation	16a. Dece	dent's Usual Occu	pation		16b. Kind of Bus		
215	hin 73	plet	(Specify only highest gr. Elementary/Secondary (0-12)	ade completed)  College (1-4or 5+)	(Give	kind of work done DO NOT use retire	during most of wor ed)	king			,
	filed wil Hygien other th	Con	12		Cas	shier/Hos	tess		Retai	1	
nd	be fill d oth	Be	17. Father's Name (First, Middle, Last	)				ne (First, Middle,	Maiden Sumame	<b>9</b> )	
3	2 should be filed within and Mental Hygiene. Is marked other then aumatic event, Ire Ma	5	Bernard Lindsey  19a. Informant's Name/Relationship	Torre Orient	405 14 77		Edna Wil				
Maryland	permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryla Deperment of Health and Mental Hygiene. Importants if Item 27 is marked other then "natural, or iteme 23a or 28a-4 ehov any fully professed or other traumatic event, it a Medical Examination that be rediffied any onches traumatic event, it a Medical Examination that be rediffied any onches.		Brenda L. Lindsey	7		-	tand Number or Ru Avenue,				•
	Health tem 27 other tr	1	20a. Method of Disposition		20b. Place of Dispe	osition (Name of		Date	20c. Location - 0		
e E	Peges nent of int: if its iry or o		1 XBurial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci		•	matory or other pla coln Ceme	1	3/06	Brentwo	od Ma	rvland
Baltimore,	permit. Peges 1 and 1 Depertment of Health Important: If Item 27 eny Injury or other tr ODGE.		21. Signature of Funeral Service Lice	<del></del>			ess of FacilityMcC				- /
<u> </u>	8258		Momos,	1. legen			gia Ave.				20012
*			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that stused the one cause of each line.	e death. Do not en	ter the mode of dy	ing, such as cardiac	or respiratory are	rest,	Inte	roximate rval Between
	Physician	1	Immediate Cause (Final disease or condition resulting in death)	a. Pancrea	atic Canc	er					et and Death
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oʻ	en an rial-tr		resulting in death) Last	Due to (or as a c	onsequence of):						
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x 68	res that the ceath certificate be executed igned by the attending physicien and be detached for use as the burial-transit	physician/Medi	IF FEMALE:					_			
Вох	attend for us	lan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of p	Fetal death 3	Ectopic pregnanc	Э		23d. Date Mon	of delivery th Day	Year
P.O.	the ce y the a	yslo	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at tim 9☐ Unknown	ie or death 5 L	Other (specify) _					
<u>а</u>	that ned by deta	hợ kạ	Part II. Other significant conditions	contributing to death but n	not resulting in the u	ınderlying cause g	iven in Part I.	23e. Did to	bacco use contri	bute to the ca	use of death?
rds	w requires been sign should be	D D	Hypertension					1 □ Y	es 21©No	3 Probably	4 □Unknown
Division of Vital Records,	aw re	Completed						24a. Was a	n 24b. W	ere autopsy f	ndings available
Ä	sician: The law certificate has b irector, page 2 s	ĕ						autop perfor	med? de	or to completeath? ☐ Yes 2∜☐	ion of cause of
/ita	clan: ertific ector.	Be	25. Was case referred to medical examiner?					th (Check only or			
of	Physi this c	2	1 Yes 2 XNo		2 ER/Outpatie	II OLI DOA		ome 5 🖾 Resid			
L <sub>C</sub>	ding I	lo	27. Manner of Death  1 2Natural 5 Pending 2 Accident Investigatio	28a. Date of Injury (Month, Day Ye	ear) 28b. Time o	Wo	ork? ]Yes 2 □No	28d. Describe h	ow injury occurre	d	
isi	deatl deatl ctor.	flca	3 Suicide 6 Could not b	00 01 11	- At home, farm, st			28f. Location (S	treet and Numbe	r or Rural Roi	ite Number
Di	alor safter i Dire	Certification:	4 Homicide	building, etc. (3	Specify)	,,		City or Tow	n, State)	, 0, 1,0,0,7,00	ito Namooi,
	To the Hospital or Attending Physician: The law requires that the ceath certificate be executed within 24 burs after death.  Within 24 burs after death.  To the Funeral Director: After this certificate has been signed by the attending physicien and spompletely filled in by the tuneral director, page 2 should be detached for use as the burial-transit		29a. Certifier 1 X Certifying Pl	nysician: To the best of m	ny knowledge, deat	h occurred at the t	ime, date and place	, and due to the o	ause(s) and man	ner as stated.	
	the Him 24 the Fu	Medical	Sile)	miner: On the basis of ex and manner stated	amination and/or in			rred at the time, o	late and place, ar	nd due to the	cause(s)
	To with	2	29b. Signature and title of certifier				se number		9d. Date signed		
	(4) (t)		* XXXX			D28	<b>05</b> 6	F	ebruary	27, 20	106
			30. Name and address of person who Ravi Passi, M.D				Silver Sp	ring. Ma	ryland	20910	
* ***	Sta Registr	-	31. Date filed (Month, Day, Year) FEB 2 8 2		Signature		<b>-P</b>				
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State of Maryland / Department of Health and Mental Hygiene [] [] [ 1 - For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2006 **Physician** 23, Feb. 3:30 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 1220 East West Highway #805 Montgomery Silver Spring 8. Date of Birth (Month, Day, Yea, Sept. 25, 6. Sex If Under 1 Year | If Under 24 Hrs. | 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) Funeral 1□M 2⊠F Hours Year) Months Days 1906 Ukraine Director 128-36-5812 99 Usual Residence of Decedent death with the Maryland Show State 10c. City Town or Location Silver Spring 10a MD Montgomery 10d. Inside City Limits ir then "neturel", or items 23e or 28a-f show the Madical Examiner must be nutified at Director 1 ☐ Yes 2 No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 1220 East West Highway 20910 **USA** Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after ☐Yes 2X No Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: ģ 3 □XVidowed 4 □ Divorced Specify: Year or Dates: White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. other then " Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: If item 27 is marked other any injury or other treumatic event once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Morris Mersel Rose 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Harvey Brill 606 McNeill Rd., Silver Spring, MD 20910 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, Slate **KX**Burial 2 ☐ Cremation, Beth David Cemetery 3 □Removal from State Feb. 26, 2006 Elmont, NY 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Savice Licensee 22. Name and Address of Facility Torchinsky Hebrew Funeral Home 254 Carroll St., NW, Washington, DC 20012 23a. Part? Enter the disease, or complication; that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cau is on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Arrythmia /Medical Due to (or as a consequence of) Myocardial Infarction **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, attending physiclan Physician/Medical as IF FEMALE: 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ō in the past 12 months? 1 ☐ Yes 2 ☐ № 0 Dav Year 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 9 Unknown þ Part II. Other significant conditions contributing to death bul not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Diabetes 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Minknown Completed Coronary Artery Disease 24a. Was an autopsy performed? 24b. Were aulopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ( No or Attending Physicien: in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death Check on one Hospital: 2 1 ☐ Yes 2 ☐ No Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide filled 24 hours a race Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

— Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. To the within 2 To the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 19600 24-06 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Raman Tuli, MD 10810 Darnestown Rd., Gaithersburg, MD 20878 31. Date filed (Month, Day, Year) State FEB 28 Registrar Angel Car

Registrar

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3. Time of Death

26mths

1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day February 21 **Physician** Pauline Burke /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 205 Prospect Bay Dr. East Grasonville If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 ☐ M 2 🕅 F 80 564-28-7814 Director Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location Pages 1 and 2 should be filed within 72 hours after death with the Marylan nent of Health and Mental Hygiene.
ant: if Item 27 is marked other than "naturel; or iteme 23a or 28e-1 show any or other than "naturel" or other than any or other than a law of the marked of t Director Queen Annes Grasonville 10e. Street and Number 10f. Zip Code 205 Prospect Bay Drive, East 21638 Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No ff Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-ff Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes X No Specify: Completed by 3₩Vidowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be August Pilacelli Johanna Ryan 19a. Informant's Name/Relationship (Type, Print) Stephen M. Burke (Son) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State permit. Page Depertment o Important: If eny injury or once. 4 Donation 5 Other (Specify) Lakemont Mem. Gdns 2-25-2006 21. Signature of Funeral Service iconsee 22. Name and Address of Facility
Hardesty Funeral Home, P.A 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** AUDY Biscone (pronaey /Medical Due to (or as a consequence of): Examiner Vasulan Bevere Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed the attending physicien and hed for use as the buriat-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 4 Pregnant at time of death 5 Other (specify) certificete has been signed by irector, page 2 should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Hyporcholemolemo Completed 24a. Was an HOW autopsy aroni milanon Khal 1 Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home Certification: To 1 Yes 200 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death

Month Year 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

28c. Injury at Work?

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 29a Certifier

5 Pending investigation

6 Could not be

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier RUPAL -K-DUSAN

1 Natural

2 Accident

3 Suicide

Why

D0061688

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2108

FEB 2 7 2006

WPM R. DESMI 31. Date filed (Month, Day, Year)

Di Donato 32. Signature

State Registrar

After

To the Funeral Director: , completely filled in by the t

Medicai

within 24 hours a To the Funeral I

2006

4c. County of Death

Queen Annes

 Birthplace (State or Foreign Country) Aug. 8, 1925 California

10d. Inside City Limits

1 Yes 2 No

10g. Citizen of What Country?

USA 14. Race - American Indian,

Black, White, etc. White

16b. Kind of Business/Industry

Own Home

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

205 Prospect Bay Dr., E., Grasonville, MD 21638

20c. Location - City or Town, State

Davidsonville, MD

12 Ridgely Avenue, Annapolis, MD 21401

Approximate Interval Between Onset and Death

23d. Date of delivery

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

5 Desidence 6 Other (Specify)

28d. Describe how injury occurred 1 Yes 2 No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29c. License number 29d. Date signed (Month, Dey, Year)

123/06

Charter MD 21619

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		_	State of Ma						_	_	Die.	
		1 - For State Registrar	Olato of Mic	ar y tarr			te of L			Reg. No.	6	J//16
		Decedent's Name (First, Middle, Last)							2. Date of De		Year	3. Time of Death
Physic /Medi		John Joseph Bowers	, Sr.						Februa	ry 23	ded	0520M
Exami	ner	4a. Fecility Name (If not institution, give st.		Llac	-1-1	4b. City	Town, or	Location of Death	h	4c. County	of Death	برطاء
Funeral		5. Social Security Number 6. Sex	neral 7. Age	e (In yrs.	last birthday)		er 1 Year	If Under 2* Hrs.	8. Date of Bir	-		
Director			M 2□F	67	Yrs.	Months	Days	Hours Min.	8. Date of Bir (Month, Da Feb 5	1939	Mary	place (State or Foreign htry) Land
pue M		Usual Residence of Decedent  10a. State 10b. County		10c. Cit	y, Town or L	ocation						10d. Inside City Limits
Marylend -f ehow	Ö	Maryland Dorchester			bridge							1 XYes 2 □ No
Z e e e	irec	10e. Street and Number				_	ip Code			10g. Citizen of	What Cou	ntry?
death with the ms 23e or 28e	Funeral Director	520 Glenburn Avenue					216				USA	
ltems e g	n n	11. Marital Status  1 □ Never Married 2 □ Married	<ol> <li>Was Decedent I Armed Forces?</li> <li>1 ☐ Yes 2 ☐ N</li> </ol>		.S. 13.	Was Dec If Yes, sp	edent of Hi ecify Cuba	spanic Origin? (S n, Mexican, Puerl	pecify Yes or No to Rican, etc.)	b- 14. Rad Blad	ce - Ameri ck, White,	can Indian, , etc.
be filed within 72 hours after death with the Marylen tal Hygiene.  Ide Hygiene.  Ide Hygiene and the Marker of the Marylen the Marylen the Marker the Marylen to the Maryl	þ	3 ☐ Widowed 4 ☑ Divorced	If Yes, Give Year or Dates:	••		1 🗆 Yes	2 🔀 No	Specify:		Specify	y: W	hite
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within 100.	mpi	Elementary/Secondary (0-12)	College (1-4or 5	+)			i pmer	) nt Operat	tor	Cons	truci	tion
e filed within al Hygiene.		17. Father's Name (First, Middle, Last)								, Maiden Suman		
should be fill of Mental Hy marked oth	To Be	Samuel O. Bowers,	Jr.					Georg	gia Conr	ad		
2 sh and and eum		19a. Informant's Name/Relationship (Typ						and Number or Ru				p Code)
ICE, IN		John J. Bowers, Jr.	/Son	20b. P	6308 Place of Disp			Lane, Hu	orlock,	MD 21643 20c. Location		own. State
Daltimor permit. Pages: Department of the Importent: If ite any injury or of		1 ☐ Burial 2 ☒ Cremation 3 ☐ Re	moval from State	C	natory	matory or	other plac	·	/2006	Delmar,		
Dailling  bermit. Pages Department of mportent: If it in the injury or one		21. Signature of Fineral Service License	00	1 1	1 2	2. Name	and Addres	s of Facility				
Depariment of the permit of th		January J	Selle		_ IC	6 Ma	in St	ral Home reet, Ea	st New	Market,	$^{\prime}$ MD 2	21631
		shock, or heart failure. List only one	ations that caused cause on each lin	the deat	h. Do not en	iter the mo	ode of dyin	g, such as cardia	c or respiratory a	rrest,		Approximate Interval Between Onset and Death
Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death) a.	SEPTI	0	SH	ock						
Examiner			Oue to (or as	a conseq	uence of):							
	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a conseq	uence of):							
<b>bu</b> , be executed iclen and burial-transit	Examiner	Cause (Disease or injury that initiated events c. resulting in death) Last	Due to (or as									
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Ords, P.O. BOX 68/60, requires thet the death certificate be executed een signed by the attending physicien and hould be detached for use as the buriat-transit.	Physician/Med	230. was decedent pregnant	ic. If yes, outcome			□Ectonic	pregnancy				ate of deliv	
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COTOS, P. w requires thet is been signed be set in should be detailed.	d by								1 🗆	Yes 2 No	3 🏻 Pro	bably 4 Unknown
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ION th. : Afte	ation	1 Natural 5 Pending 2 Accident investigation	(Month, Da	ý Year)	Injury	М	Worl	k? Yes 2 □ No				
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To tha I within 2 To the I complet	Me	29b. Signature and title of certifier					9c. Licens			29d. Date signe		
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		30. Name and address of person who cor	mpleted cause of d	leath (Iter	п 23а) (Туре	, Print)	C	633 CAMB	PIDO-	1.40	211	12
	ate	MAHOUSA HUH 31. Date filed (Month, Day, Year)	72K)	300 ar's Signa	HUK ature	OKA	31,	CAIMB	KIDGE	, MU-	010	2
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	the Maryland	Director	10a. State 10b. County  MARY LAND MONTGOM  10e. Street and Number	ERY	10c. C	ity, Town or Lo	TA		PARK					t 0d. Inside City Li	
9800	be filed within 72 hours after deeth with the Maryland ttal Hygiene. of other than "natural", or Itams 23a or 28a-f ahow avant, the Madical Evanificat must be notified at	by Funeral	7620 MAPLE AVENUE  11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	, APT. 43  12. Was Decede Armed Force 1  Yes 2 If Yes, Give Year or Date	nt Everin Ues? ∭XNo			edent of Hi ecify Cuba	912 spanic Origin n, Mexican, P Specify:	? (Speciruento Rid	ly Yes or No- can, etc.)	14	U • S  4. Race - Ame Black, White Specify: WI	· A · erican Indian,	
21215-0036	within 72 h ene. than "natu he Medical	Completed	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12)	ade completed) College (1-4	or 5+)	life.	kind of w DO NOT	ork done d use retired	luring most of )			16b. Kind	d of Business	/Industry	
Q	uld be filed within Mental Hygiene. Irked other than '	Be	17. Father's Name (First, Middle, Last	5+		SENIOR	R FIN			Name (I	First, Middle, M	Maiden S	CA FACT	TORY	
, Maryland	permit. Peges 1 and 2 should be Depertment of Heelth and Menta Important: if item 27 is marked any injury or other traumatic av ODCE.		19a. Informant's Name/Relationship				-	s (Street a	and Number o	r Rural F	Route Number,	City or		Zip Code) 20855	
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8760,	Physician /Medical Examiner and physician and physician and the prival-transit time prival-transit	cai Examiner	shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, If any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. OVARIA  Due to (or  b. Due to (or  c.		quence of):								Interval Betweer Onset and Death	
.O. Box 6	Physician: The law requires that the death cartificate this certificate has been signed by the ettending phyrial director, page 2 should be detached for use as the	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 分 No 9 □ Unknown	23c. If yes, outcor 1 □ Live birth 4 □ Pregnant 9 □ Unknown	2 ☐ Feta at time of c	aldeath 3	Ectopic p	pregnancy				23	d. Date of del Month	livery Day Year	
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12	,	9	30. Name and address of person who DR. JOSEPH KAPLAN,			דדדא מי	RΩΔI	D, RO	CKVILL	Е, М	[ARYLAN]	D 2	0855		
	Sta Registr	te	31. Date filed (Month, Day, Year) FEB 2 7 20	. ₹. Regi	strar's Sign		de l								

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** ELISHA FEBRUARY 22, 2006 17:20 BARSKY /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner SHADY GROVE ADVENTIST HOSPITAL MONTGOMERY ROCKVILLE If Under 1 Year tf Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours **№** M 2□ F 84 Yrs. Director 010-14-4783 01/19/1922 NEW YORK Usuat Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyglene. Important: If item 27 is marked other than "naturel", or iteme 23s or 28s-f ehow printy or other traumatic event, the Medical Examinar must be notified at once. 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 XYes 2 No MARYLAND MONTGOMERY SILVER SPRING Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20906 U.S.A. 3408 CHISWICK COURT #3e e filed within 72 hours after death in Hyglene.
I Hyglene.
I other than "naturel", or Iteme 23: Funeral 12. Was Decedent Ever in U.S. Armed Forces? NUTYes ≥ 2 □ No If Yes, Give Year or Dates: 1942–46 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: WHITE þ 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Cotlege (1-4or 5+) Elementary/Secondary (0-12) GOVENMENT ELECTRONIC TECHNICIAN 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) FANNIE FREIMAN CHARLES BARSKY 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 5208 WHITE FLINT DRIVE, KENSINGTON, MARYLAND 20895 LISA STRAUSS/DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State MT. LEBANON CEMETERY 2/26/2006 ADELPHI, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 21. gnature of Funeral Service 22. Name and Address of Facility EDWARD SAGEL FUNERAL DIRECTION, INC. 1091 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 20852 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** DSI disease or condition resulting in death) /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner ending physician and use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical ed by the attending of detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1□ Yes 2 No Hospital or Attending Physician: tor: After this certific the funeral director, 25. Was case referred to medical Be 26. Place of Death | Check only one Hospital: 1 Appatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 1 ☐ Yes 2 ☐ No death. investigation 24 hours after deat Funeral Director: 6 Could not be determined 3 Suicide 28e. Ptace of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier cal To the Hosp within 24 hor To the Fune completely fi (Check only one) 29c. License number 29b. Signature and title of certifier 2401 Reserved Blue M()30. Name and dr ss of person who completed cause of death (Item 23a) (Type, Print) MENDHIRAT Dr ANURITA 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2 7 FEB Registrar

			State of Maryland / Department of Health and N	•	•	
			1- For State State Control of Teach and Teach		Reg. No. 0 0 6	07719
			Decedent's Name (First, Middle, Last)	2. Date of De	ath	3. Time of Death
	Physici: /Medic	_	Elizabeth Baeder		Day Yee	M
9	Examin		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death	. CDI do	ry 26 2	
		•	Berlin Nursing & Rehabilitation Ctr. Berlin  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.	R Date of Bird	Worceste	
- 1	Funeral Director		124-12-5344  1 M 2 KF 94  Yrs. Months Days Hours Min.	8. Date of Birt (Month, Da Sept. 3	0. 1911Cze	inthplace (State or Foreign Country) Choslovakia
			Usual Residence of Decedent	,	-,	
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	ems 2	Funeral	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	pecify Yes or No	- 14. Race - An Black, Wh	
36	or It	by Fu	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🕅 No If Yes, Give 1 ☐ Yes 2 🖾 No Specify: Year or Dates:		Specify: Wh	ite
္မဝ	be filed within 72 hours atter death with the Maryland Ital Hygiene. d other than "natural", or Items 23e or 28e-f show avent, I're Medical Examitrer in that he notified at	ed b	15. Decedent's Education 16a. Decedent's Usual Occupation		16b. Kind of Busines	s/Industry
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izano	should be filed withir na Mental Hygiene. marked other than imatic avent, ITE M.	Be c	John Blazek  18. Mother's Name  Katherir			
Elizabeth Maryland 21215-0036	2 should and Men is marke raumatic	ပ	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Run			Zip Code)
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aeder iimore,	es 1 a of He of Heπ if iteπ or oth		1 Novice 3 Comparison 3 Removal from State cemetery, crematory or other place)	Date	20c. Location - City of	
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Bal	permit. Departn Imports any inju		21. Signature of Fundal Service Licensee 22. Name and Address of Facility The	e Burbag Berlin	e Funeral	Home
			23a. Fart 1. Enter the discrete second complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or he intraliure. List only one cause on each line.			Approximate Interval Between
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Вох 6	certifi nding use as	√/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy		23d. Date of d	elivery
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	The law requires that the death certificate be executed tte has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	1		Probably 4) Unknown
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'ital	ctor. p	BeC	25. Was case referred to medical examiner?			
of V	Physician: r this certitics ral director,	ို	1 ☐ Yes 25 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Ho		dence 6 Other (Sp	ecify)
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ā	tal or rs afte al Dire	Certification;				
	To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: Atter this certificate his completely tilled in by the funeral director, page	Medical	29a. Certifier Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, Check only Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, contact the contact th	and due to the red at the time,	cause(s) and manner date and place, and d	as stated. ue to the cause(s)
	o the o the omple	Med	29b. Signature and little of certifier 29c. License number		29d. Date signed (Mo	yh, Day, Year)
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_	- 10		30, Name and address of person who completed cause of death (Item 23a) (Type, Print)  Nicholas Boradul (a, a) (209 lovested H	. 1	T 4.	T/ 12940
2	T 10	7	3. Date filed (Month, Day, Ygar)  32. in gistrar's Signature	tanway	Penvill-	tsked, De
	Sta Registi		31. Date filed (Month, Day, Year) FEB 2.8 2006 See F. Joseph			

of Vital Division

The law requires that the death certificate be executed be detached for use as the burial-transit the attending physicien page 2 should has certificate funeral director, this To the Hospital or Attending within 24 hours after death. To the Funeral Director: A the in by completely filled

Physician

/Medical

Examiner

**Funeral** 

Director

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Pages 1 and 2 should be fit iment of Health and Mental H tant: If Item 27 Is marked other.

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Completed by Physician/Medical

Medical Certification: To Be

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fited within 72 hours after death with the Maryland

Maryland 21215-0036

Baltimore,

State

29b. Signature and title of certifier Wasn 30. Name and address of person who completed cause of death (Item 231) (Type, Print)

Swann. M.D. 8600 OYd Georgetown Road, Bethesda, MD 20814

2006

29c. License number

29d. Date signed (Month, Day, Year)

31. Date filed (Month, Day, Year) FEB 28 32 Registrar's Signature

Registrar

			For State Registrar	State o		eartment of Health a		giene	07722
	Dhomisi		1. Decedent's Name (First, Middle, L	ast)			2. Date of Dea Month		3. Time of Death
	Physicia /Medic		Catherine Lilli	an Colvi	n			26 2006	MI LI ANI
	Examin		4a. Facility Name (If not institution, g.	ive street and nur	mber)	4b. City, Town, or Location of	Death	4c. County o	of Death
			17633 York Road			Hagerstown  of If Under 1 Year   If Under 2		Washi	ngton
	Funeral		5. Social Security Number 6.	Sex 1□M 2ਊF	7. Age (In yrs. last birthday	If Under 1 Year   If Under 2   Months Days Hours	Min. (Month, Da)	h y, Year)	Birthplace (State or Foreign Country)
	Director		213-18-8788	X - X	85 Yrs.		Jan. 2	1 1921	Maryland
	and *		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or L	ocation			10d. Inside City Limits
	Aaryl I sho	ō	Marral 1 II 1 1		-				1 ☐ Yes 2 No
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	Itam Itam	Funeral Director	1 ☐ Never Married 2 ☐ Married	Armed Fo	rces?	. Was Decedent of Hispanic Origi If Yes, specify Cuban, Mexican,	Puerto Rican, etc.)	Black	k, White, etc.
99	urs af	by I	3 Widowed 4 Divorced	If Yes, Giv Year or D	re -	1 ☐ Yes 2 No Specify:		Specify:	White
Š	72 hours after death with the Maryland natural', or Itams 23a or 28a-f show Jisal Exertinet: wat be notified at		15. Decedent's			edent's Usual Occupation	,	16b. Kind of Bus	
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	be filed ital Hygie d other svant, II	Be (	17. Father's Name (First, Middle, Las	st)		18. Mother	's Name (First, Middle,	Maiden Surname	))
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at	Departi Departi Importi any inj		21. Signature of Funeral Service Lic	ensee		22. Name and Address of Facility	Minnich		1.00
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ec	law as b	nple					24a. Was autop	sy pr	/ere autopsy findings available rior to completion of cause of
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Division	l or Attendater death Director:	ertification:	4 Homicide determine	d 289. Place	of Injury - At home, farm, s ng, etc. <i>(Specity)</i>	treet, factory, office	City or Tow		r or Rural Route Number,
Ц	Hospital or Al	O	29a. Certifier 1 Certifying	Shyrainian, To the	hast of my knowledge, does	the common of the time of the cond	Lalana and due to the		
	Hos Fundal	edical	(Check only one)	aminer: On the b	asis of examination and/or i ner stated.	ath occurred at the time, date and investigation, in my opinion, death	n occurred at the time,	date and place, as	nd due to the cause(s)
	4540	Mec	29b. Signature and file of certifier?	7	A	29c. License number		29d. Date signed	(Month, Dey, Year)
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7			20 None and die	Completed -	on of death (to= 22=) m	DOUT 1)	1	tebruara	y 28 2006
15	H-7		30. Name and address of person wh	o completed caus	e or death (Item 23a) Mype	1 Hace retain	nmn	21741	2
	Sta	te	31. Date filed (Month, Day, Year)		egistrar's Signature	1115000	1101	0,.,	
	Registr		MAR 01	2006	neva B. A.	perker			

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Eva O. Coyle February 3, 2006 9:30 P. /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Wilson Health Care Center Gaithersburg

If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. Montgomery 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 M 2 F Yrs. Director 132-01-9942 Feb. 10, 1911 Sweden Usual Residence of Decedent 10a, State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 ☑ Yes 2 ☐ No Maryland Director Montgomery Gaithersburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 301 Russell Avenue 20877 S. Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 ☑ No
If Yes, Give
Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: 3 Nidowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. ant: If item 27 is marked other than ' Elementary/Secondary (0-12) College (1-4or 5+) 12 Years Owner-Operator Hardware Store 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Victor Olson Ellen Svenson ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Barbara E. Bullman - Guardian 107 North Adams Street, Rockville, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages
Department of important: If its any njury or o 1 ☐ Burial 2 X Cremation 3 X Removal from State 4 ☐ Donation 5 ☐ Other (Specify) National Crematory 2/28/200 Falls Church, Virginia 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
Danzansky-Goldberg Memorial Chapels, Inc. Donald 1170 Rockville Pike, Rockville, Maryland 23a. Part 1. Enter the disease, or complications that caused the stath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each ling. Approximate Interval Between Onset and Death Priysician ement disease or condition resulting in death) ears /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examiner or Attending Physician: The law requires that the death certificate be executed burial-transit cause (Cisease or inju-that initiated events resulting in death) Last physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☑ No Day 4☐Pregnant at time of death 5 Other (specify) ed by the a detached f 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ ed bluods 1 Yes 2 No 3 Probably 4 JUnknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed Yes 2 No 1 🗆 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ပ္ 1 Tes this s after death. Il Director: After this Id in by the funeral d 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Tes 2 □No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai To the 29b. Signature and title Ocertifier 29d. Date signed (Month, Day, Year) 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 911 6 zithersburg Ave.  $\subset$ Teven LUSSCII olinst 31. Date filed (Month, Day, Year) Registrar's Signature State 2006 Registrar Super.

			For State Registrar	State of Marylar		artment of F			Reg. No.	6 3 3 4 2 4	07724
75	Physicia	an	1. Decedent's Name (First, Middle, Las Herbert Warren	Cooper, III				2. Date of De Month Febru		20, žöó6	3. Time of Death 12:30p M
	/Medic Examin		4a. Facility Name (If not institution, given 7211 Windsor Lane			4b. City, Town, o		eath		County of Death Prince G	eorge's
	- Funeral Director		395-14-3763	ex 7. Age (In yrs.		If Under 1 Year Months Days		8. Date of Bir (Month, Da July 1	th 19, Year) 19, 1	9. Birth Cour 920 I]	place (State or Foreign ntry) Llinois
	Maryland I show	tor	Usual Residence of Decedent  10a. State 10b. County  Maryland Prince		ty, Town or Lo						10d. Inside City Limits 1 ☐ Yes — No
	a or 28s	i Direc	10e. Street and Number 7211 Windsor Land	-		10f. Zip Code 20782			10g. Citi USA	izen of What Cou	ntry?
980	is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other then "naturel", or items 23s or 28s-f show other traumatic event, the Maryland Examinar must be positive as	by Funeral Director	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1女Yes 2☐No If Yes, Give Year or Dates:1943 -		Was Decedent of H If Yes, specify Cub-	dispanic Origin? an, Mexican, Pi Specify:	(Specify Yes or No uerto Rican, etc.)	0-	14. Race - Ameri Black, White, Specify hite	etc.
21215-0036	within 72 horelene. Then "nature the Western the Western the Medical the Medic	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)		(Give	dent's Usual Occup kind of work done DO NOT use retire gineer	during most of	working		ind of Business/Ir	
Maryland 2	uld be filed Mental Hygid irked other itic event, il	To Be C	17. Father's Name (First, Middle, Last) Herbert Warren C					Name (First, Middle rta D. Da		Sumame)	
di.	1 and 2 sho Health and N Iem 27 is ma other trauma		19a. Informant's Name/Relationship (1)  Robert W. Cooper  20a. Method of Disposition	/ Son	7211	Windsor	Lane, H	r Rural Route Numb yattsvill Date	e, M		
Baltimore,	permit. Pages 1 Department of H Important: If Its any Injury or ot		1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify 21. Signature of Funeral Service Licen	y) Gat	te of He	matory or other pla aven Cemete 2. Name and Addre rancis J	ery Facility	ruary 25, 2006 ns Funera	Silv 1 Ho	me Inc.	ng, Maryland Lng, MD 2090
A	Physician /Medical Examiner and prutal-transit	Examiner	23a. Part 1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, it any, feeding to fail additionable cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	plications that caused the deal one cause on each line.  a. Carcinoid Tu  Due to (or as a consect  c. Due to (or as a consect  Due to (or as a con	umor of quence of):		ng, such as car	diac or respiratory a	arrest,		Approximate Interval Between Onset and Death 2 Years
O. Box 68760,	death certificate e attending phy d for use as the	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No	d.  23c. If yes, outcome of pregn 1 □ Live birth 2 □ Fet 4 □ Pregnant at time of o	al death 3	□Ectopic pregnanc □ Other (specify) _	у			23d. Date of deliv Month	ery Day Year
rds, P	w requires that been signed should be del	þ	Part II. Other significant conditions of Hypertension	contributing to death but not re	sufting in the I	underlying cause gr	ven in Part I.		tobacco i Yes 2		the cause of death?
I Records,	The la ate has page 2	Completed						24a. Was auto perf 1 Yes		prior to co	opsy findings available ompletion of cause of 2 No
on of Vital	Attending Physician: 'r death. c death. ector: Atter this certifica by the funeral director, p	To Be	25. Was case referred to medical examiner?  1  Yes 2 No  27. Manner of Death  1 Natural 5 Pending investigation investigation	28a. Date of Injury (Month, Day Year)	ER/Outpatie 28b. Time o Injury	of 28c. Inju Wo	ner: 4 ☐ Nursin	Death (Check only  ng Home 5 XRes  28d. Describe	idence		fy)
Division	al or Attend s after death al Director:	Certification:	3 Suicide 6 Could not b 4 Homicide determined		nome, farm, si ify)	treet, factory, office	mroce - III.	28f. Location City or To	(Street ar own, State	nd Number or Rui a)	al Route Number,
	To the Hospital or within 24 hours after To the Funeral Director completely filled in D	edical		nysician: To the best of my kn niner: On the basis of examin and manner stated.							
	within 2	×	29b. Signature and title of certifier	colons	>	29c. Licen:	se number 1119			te signed (Month)	
	( -		30. Name and address of person who Daya S. Sharma, MI	1400 Forest (	Glen Ro	oad, #435	, Silve	r Spring,	MD	20910	
	Sta Regist		31. Date filed (Month, Day, Year) FEB 2 7 2	32/Registrar's Sign	ature	ande					

			For	State of I	Marylan	•			and Mental I	Tygler	on a	07725
		do	1 - State Registrar			Cei	rtificate of	Death	2. Date o	Reg.(	No.U U U	01120
***	Physici	an	Decedent's Name (First, Middle,						Month	. [	Day Year	2 1 1 7 7 7 4 14
13	/Medic		Ronald Da.  4a. Fecility Name (If not institution,		orl		4b. City, Town, o	or Location	Marc of Death		4c. County of De	-
	Examin	ier	Washington Cour					lagers			Washin	
	Funéral	\$ (48)			Age (In yrs.	last birthday)	If Under 1 Year	If Under	24 Hrs. 8 Date o	f Birth	9 Bi	rthplace (State or Foreign
	Director		572-84-6663	1 <b>X</b> M 2□ F	51	Yrs.	Months Days	Hours	Min. Oct.	8,19	54	Maryland
	P _		Usual Residence of Decedent		1							
	anyla:	_	10a. State 10b. County		10c. Cit	y, Town or Lo						10d. Inside City Limits 1X Yes 2 ☐ No
	8a-f	octo		ington		ŀ	Hagerstow	m				
	s or 2	Funeral Director	10e. Street and Number				10f. Zip Code	1742		10g.	Citizen of What C	.S.A
	e 23	erai	412 Vermont A	ve .	nt Ever in II	S 12			inin? (Specify Ves o	r No-	14. Race - Am	
	Item Item	-E	1 XNever Married 2 Marrie	Armed Force	es?	.5.	If Yes, specify Cub	an, Mexica	igin? (Specify Yes o n, Puerto Rican, etc.	)	Black, Wh	ite, etc.
920	urs af	þ	3 Widowed 4 Divorced	If Yes, Give Year or Date			1 ☐ Yes 2 🛛 No	Specify:			Specify:	White
Ö	filed within 72 hours after death with the Maryland Hygiene. other then "natural", or Iteme 23a or 28a-f ehow ent, the Madical Examinat must be notitied at	Completed	15. Decedent's (Specify only highest	Education		16a. Dece	dent's Usual Occup	oation	at of working	16b	. Kind of Busines	s/Industry
21215-0036	en "r	npie	Elementary/Secondary (0-12)	College (1-4	or 5+)	life.	kind of work done DO NOT use retire	d)	st of working			
2	ed wi	Con	11				Printe				Printin	g Co.
Maryland	tal H d oth	Be	17. Father's Name (First, Middle, La	_				18. Moth	er's Name (First, Mi		•	-
7/8	Mer Marken Marken Marken Marken	은	Donald F.			105 11-11					Wilkinso	
Ma	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other then "natural", or Iteme 23a or 28a-f ehow way injury or other traumatic event, the Madical Examinat must be notified at ODGs.		19a. Informant's Name/Relationshipshipshipshipshipshipshipshipshipship			Acces -			er or Rural Route No Hagersto			
	1 and Healt em 2 thar		20a. Method of Disposition	s (MOLHEL)	and produce of the large of the large of the	1	osition (Name of matory or other pla		Date		Location - City o	
nor	ages int of t: If it		1X Burial 2 ☐ Cremation 3			emetery, crei own Cer		C8)	March 13, 2006		oxville,	
Baltimore,	artme ortani injury	1 1	4 □ Donation 5 □ Other (Special Signature of Funeral Service Li		210		2. Name and Addre					
Ba	Dermi Depa Impo eny is		) ICO /	1	e Me				eral Home	Smit	5 Bradbu hsburg.M	d. 21783
			23a. Part1. Enter the disease, or co shock, or heart failure. List or									Approximate
	Physician		Immediate Cause (Final	One cause on each	n line.				· Pulmey		Ceise	Interval Between Onset and Death
100	/Medical	8	disease or condition resulting in death)	a. Due to or	as a conseq	Labora of/:	NIC CLUST	my	MINUS		ساديون	1/80/25
4	Examiner					uerice or).			//			y
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		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or	as a conseq	se			Ü			years
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50,	oe execute cian and ourial-trans	i Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	as a consequence	uence of):			Ü			years
8760,	cate be executed physician and the burial-transit	icai	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	<u> </u>	uence of):		in the second	Ü			years
68	sertificate be execute ding physician and se as the burial-trans	icai	resulting in death) Last  IF FEMALE:	c	as a consequ	uence of):			U			7
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	State of Marylar	nd / Department of Health and Menta Certificate of Death	
	Registrer  1. Decedent's Name (First, Middle, Last)		Reg. No.
Physicia			of Death nth Day Year 1,30 A M
/Medica	a me title and the second of t	IMa	ron arabou de "
Examine		4b. City, Town, or Location of Death	4c. County of Death
	Lions Manor Nursing Home  5. Social Security Number 6. Sex 7. Age (In yrs.	Cumberland  [ast birthday] If Under 1 Year   If Under 24 Hrs.   8, pate	Allegany
Funeral	100 00 1051 10 M 2 TVF	Months Days Hours Min. (Mo	e of Birth onth, Day, Year)  9. Birthplace (State or Foreign Country)
Director	Usual Residence of Decedent	74 Yrs. July	7 18, 1931 MD
rland ow		ty, Town or Location	10d. Inside City Limits
Many Many	MD Washington Har	ncock	1 ☐ Yes 2 X No
with the Maryland e or 28a-f show Lbs nutilised at	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
3a or	MD Washington Hail 10e. Street and Number 14815 Bottenfield Road  11. Marital Status 12. Was Decedent Ever in Uarmed Forces? 1   Yes 2 Milkon   1   Yes 2 Milkon   1   Yes 2 Milkon   1   Yes 2 Milkon   1   Yes 2 Milkon   1   Yes 2 Milkon   1   Yes 2 Milkon   1   Yes 2 Milkon   1   Yes 2 Milkon   1   Yes 2 Milkon   1   Yes 2 Milkon   1   Yes 2 Milkon   1   Yes 2 Milkon   1   Yes 2 Milkon   1   Yes 2 Milkon   1   Yes 2 Milkon   1   Yes 2	21750	
death death ims 23	11. Marital Status 12. Was Decedent Ever in U		s or No- 14. Race - American Indian,
T the state of the	Armed Forces?  1 Never Married 2 Married 1 Yes, 2 No If Yes, Give		etc.) Black, White, etc.
OO36 hours after tural; or its	□ 31X Wildowed 4 Li Divorced Year or Dates:	1 ☐ Yes 2 🔯 No Specify:	Specify: White
Mary 15-0036	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)	16a. Decedent's Usual Occupation	16b. Kind of Business/Industry
2 File 19	Elementary/Secondary (0-12) College (1-4or 5+)	(Give kind of work done during most of working life. DO NOT use retired)	
2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	8	Homemaker	Own Home
nd nd High	17. Father's Name (First, Middle, Last)	18. Mother's Name (First,	Middle, Maiden Sumame)
TCEK,  Iryland 2121 should be filed within to Mental Hygiene. marked other than 'matic evant, the Me	John O. Price	Lola Creek	Χ
- / 00 % & m 2	19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route	Number, City or Town, State, Zip Code)
or Health itam 27	Dianna S.Hartley/Daughter	_ 35108 Whitfield Road, NE Li	ittle Orleans,MD 21766
Baltimore, permit. Pages 1 at Department of Hea Important: If item any injury or otha	20a. Method of Disposition 1 → Burial 2 □ Cremation 3 □ Removal from State	Place of Disposition (Name of Date cemetery, crematory or other place)	20c. Location - City or Town, State
Baltimorr permit. Pages: Department of F Important: If its any injury or of		ney Plains Cemetery 03/04/06	Little Orleans.MD
Balt permit. Depart Import any inj	21. Signature of Funeral Security Licensee	22. Name and Address of Facility	141 West Main Street
m #9F#9	Kuch Pl	Grove Funeral Home, P.A.	
	23a. Part1. Enter the disease, or complications that caused the deat shock, or heart failure. List only one cause on each line.	h. Do not enter the mode of dying, such as cardiac or respin	atory arrest, Approximate Interval Between
Physician	Immediate Cause (Final disease or condition	Syndrome	Onset and Death
/Medical	resulting in death)  a  Due to (or as conseq		100009)
Examiner	Sequentially list apaditions		
( n =	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	uence of):	
/60, / he executed sician and burial-transit	Cause (Disease or injury that initiated events c.		
9 exe lan a urrial-		uence of):	
9 % 9			
Box 68 Box certifica sath certifica attending ph for use as th	IF FEMALE:		
SON Ith ce tendi	23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnant 1 Live birth 2 Feta	ancy Il death 3⊡Ectopic pregnancy	23d. Date of delivery
e dea e dea he at he at	1 Yes 2X No 4 Pregnant at time of d		Month Day Year
Is, P.O. Box 68 res that the death certifica igned by the attending ph be detached for use as the by Device Internal for the by Device Internal for the properties of the prop	9 ☐ Unknown		
dS, P.(  Jires that the signed by doe detac	Part II. Other significant conditions contributing to death but not res	ulting in the underlying cause given in Part I. 236	e. Did tobacco use contribute to the cause of death?
The law requir			1 ☐ Yes 2 ☐ No, 3 ☐ Probably 4 ☐ Unknown
law las b		248	a. Was an 24b. Were autopsy findings available prior to completion of cause of
The The page		1□	performed? death? Yes 2/2 No 1 Yes 2/2 No
/ita	25. Was case referred to medical	26. Place of Death Check	
hysic his co	1 Yes 2 No Hospital: 1 Inpatient 2	ER/Outpatient 3 DOA Other: 4 Jursing Home 5	Residence 6 Other (Specify)
on of Vital Redding Physician: The law h. After this certificate has funeral director, page 2	27. Magner of Death 28a. Date of Injury (Month, Day Year)	28b. Time of Injury at Work? 28d. Des	scribe how injury occurred
SiO andi andi or: A or: A	2 Accident investigation	M 1 Yes 2 No	
Division of Vital Records, for Attanding Physician: The law requires to after death.  Director: After this certificate has been signed in by the funeral director, page 2 should be contification. To Be Completed by	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At the building, etc. (Specific	ome, farm, street, factory, office 28f. Loca City	ation (Street and Number or Rural Route Number, or Town, State)
Division of Attan or Attan ours after deal areal Director: filled in by the			
Division of Vital Records, P.O. Box 68  To the Hospital or Attanding Physician: The law requires that the death certifical within 24 hours after death.  To the Funaral Director: After this certificate has been signed by the attending phy completely filled in by the funaral director, page 2 should be detached for use as the Medical Certification.	29a. Certifier  (Check only  (C	wledge, death occurred at the time, date and place, and due tion and/or investigation, in my opinion, death occurred at the	to the cause(s) and manner as stated.  e time, date and place, and due to the cause(s)
To tha Hos within 24 h within 24 h completely	one) and manner stated.  29b. Signature and title of certifier	29c. License number	
F W F O	Workoff MD		29d. Date signed (Month, Day, Year)
		#D55325	march 02, 2006
3	30. Name and address of person who completed cause of death (Item	Tarn Terrace Frostb	110 110 21022
State	31. Date filed (Month, Day, Year)  32. Revistrar's Signa	dure.	urg, MD 21532
State Registrar		St. Appell	9

For

State of Maryland / Department of Health and Mental Hygiene

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	. 1	1.1	1 1	13.00
Rea.	No.	50	100	1

07727

	1 - Registrar	Cei	rtificate of Death		Reg. Ne.	01161
Physician /Medical	Decedent's Name (First, Middle, Last)     CHRISTOPHER J. COURSE	7		2. Date of De Month <b>FEBRUAR</b>	Day Year <b>2006</b>	3. Time of Death 11:55A M
Examiner	4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of	f Death	4c. County of Death	
	305 OAK STREET		CENTREVILLE		QUEEN ANN	E'S
Funeral	5. Social Security Number 6. Sex 7. Age (In	yrs. last birthday)	If Under 1 Year If Under 2 Months Days Hours	24 Hrs. Min. 8. Date of Bir (Month, Da AUG. 13	th 9. Birth	place (State or Foreign
Director	217-92-1129	27 Yrs.		AUG. 13	,1978 MARYI	AND
p >	Usual Residence of Decedent  10a, State 10b, County 10	c. City, Town or Lo	vestion			I Od. Inside City Limits
aryla hov						1X Yes 2 □ No
8a-1		CENTREVII				
death with the Maryland ms 23a or 28s-1 ehow rmust be notified at	10e. Street and Number		10f. Zip Code		10g. Citizen of What Cou	
ath v	305 OAK STREET		21617		UNITED STATE	
o after death w or items 23s niner mutti	11. Marital Status  12. Was Decedent Ever Armed Forces?	rin U.S. 13.	Was Decedent of Hispanic Orig If Yes, specify Cuban, Mexican,	gin? (Specify Yes of No , Puerto Rican, etc.)	- 14. Race - Americ Black, White,	
hours aft	1 Married 2 Married 1		1 ☐ Yes 2 <b>X</b> No Specify:		Specify: WHIT	E
IN ZIZIS-UUSO filed within 72 hours after tygiene tyter than *naturet; or ite nut, the Maulical Examina e Completed by Fu		16a. Dece	dent's Usual Occupation		16b. Kind of Business/In	
in 72 in 72 in 72 in 72 in 72 in 9 in 10 i	(Specify only highest grade completed)	(Give	kind of work done during most DO NOT use retired)	of working	ANNE ARUNDEI	•
A I A I S-Ur ed within 72 ho ygiene. Per then "natur. If, the Medical I	Elementary/Secondary (0-12) College (1-4or 5+)	DISPA	TCHER		EMERGENCY S	SERVICES
	17. Father's Name (First, Middle, Last)		18. Mother	r's Name (First, Middle	, Maiden Sumame)	
should be file and Mental Hy marked oth umatic event	DAVID WAYNE COURSEY		FRANC	CES GERMAIN	E WRIGHT	
should not Men Men Men Men Men Men Men Men Men Men	19a. Informant's Name/Relationship (Type, Print)	19b. Mailir	ng Address (Street and Number	r or Rural Route Numb	er, City or Town, State, Zip	Code)
re, Maryia s 1 and 2 should Health and Mer tem 27 le marke other traumatic	GERI WHITBY/ MOTHER	305 C	OAK STREET CEN	NTREVILLE,	MARYLAND 216	17
other	1 7 1 2 1 1 1	Ob. Place of Dispo	esition (Name of matory or other place)	Date	20c. Location - City or To	own, State
Peges ment of ment: If it	1 XBurial 2 □ Cremation 3 □ Removal from State  '4 □ Donation 5 □ Other (Specify)	, ,	ELD CEMETERY 3	/1/2006	CENTREVILLE	, MD
글 글론원등 .	21. Signature of Funeral Service Licensee	22	2. Name and Address of Facility	PETAL C MIPLIA	AM PUNIPOAT I	IOME TO A
Depariment on the contract of	Sharray oxiga	et 45	2. Name and Address of Facility LLOWS, HELFENI 08 SOUTH LIBER	TY STREET C	ENTREVILLE,	MD 21617
	23a. Part1. Enter the disease, or complications that cause ne shock, or heart failure. List only one cause in each in	death. Do not ent	er the mode of dying, such as	cardiac or respiratory a	rrest,	Approximate Interval Between
Physician	Immediate Cause (Final	CAN	100		Į.	onset and Death
/Medical	disease or condition resulting in death)  a. Due to (or as a co					100
Examiner						
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Disease of thus that initiated events c.	insequence of):				
executed in and ial-transit	Cause (Disease or Injury that initiated events					
	resulting in death) Last Due to (or as a co	ensequence of):				
ob / ou fircate be e p physicien as the burit	d					
certificate be certificate be nding physicis use as the but when the but when the but when the but will be but with the b	IF FEMALE:	.5.01				
0 - 2 -	23b. Was decedent pregnant 23c. If yes, outcome of p		Ectopic pregnancy		23d. Date of delive	,
tithe death by the atter ached for u	1 Yes 2 No 4 Pregnant at time		Other (specify)		Month	Day Year
COIDS, P.O. By we requires that the death been signed by the attershould be detached for ideated by Physicial	9 Unknown			00 5:11		
be de	Part II. Other significant conditions contributing to death but no	ot resulting in the u	nderlying cause given in Part I.		obacco use contribute to t	
w requires w requires been sign should be				11	Yes 2. Yo 3 ☐ Prot	pably 4 Dunknown
45 KB KB KB				24a. Was	an 24b. Were auto	psy findings available mpletion of cause of
The I				perfo	ormed?   death?	
VITAL INITERIAL THE CONTRIBUTION OF THE CONTRI	25. Was case referred to medical examiner?			of Death (Check only of		
OT VITA Physician: rithis certific ral director.	1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpatient	2 ER/Outpatier	The second secon	rsing Home 5 🗶 Resi	dence 6 ☐Other (Specil	(y)
JVISION OF VITCA or Attending Physician: filter death. Director: Atter this certific in by the funeral director.	27. Manner of Death 1 ☑Natural 5 ☐ Pending 28a. Date of Injury (Month, Day Ye	er) 28b. Time o	f 28c. Injury at Work?	28d. Describe	how injury occurred	
Attending ar death.  ctor: After by the fune fileation	2 Accident investigation		M 1 Yes 2 N	Vo .		
DIVISION C tal or Attending P rs after death. al Director: Attert ed in by the funera Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury building, etc. (5	At home, farm, str specify)	reet, factory, office	28f. Location ( City or To	Street and Number or Rura wn, State)	I Route Number,
To the Hospital or within 24 hours aft To the Funeral DI completely filled in						
To the Hospital To the Funeral I completely filled Medical Ce	29a. Certifier 1 Certifying Physician: To the best of m 2 Medical Examiner: On the basis of examiner	y knowledge, deat amination and/or in	h occurred at the time, date and vestigation, in my opinion, deat	d place, and due to the th occurred at the time,	cause(s) and manner as sidate and place, and due to	tated. the cause(s)
the Hosp thin 24 hou the Fune impletely fil	and manner stated	•	20a L Charles Sumbor		Ond Data stand (Marth	Day Vand
with To	29b. Signature and title of textifier		29c. License oumber	657	29d. Date signed (Month)	
	IUNUI		01/0	0 /	09-00	~
CNI	30. Name and address of person who completed cause of death DAVID H. SMITH, M.D., 29466			EASTON I	m 21601	
216	31. Date filed (Month, Day Year) 32. Registrar's		DETAIL SOTTE 7	, manione, i	21001	
State Registrar	1 FD • 7 7 001.		1. 4			
DHMH 17 Rev 1/2001	1,000	we &	post			
// I/OV I/2001		ODIGIN	۸۱			

Carole Calhoun Unpend item # 23a,27, perME,9853,3/18/06 TT State of Maryland / Department of Health and Mental Hygiene 06-01585 crn 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** CAROLE W. CALHOUN March 04 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death Atlantic General Hospital Berlin
If Under 1 Year | If Under 24 Hrs. Worcester 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Months Days Hours 1 ☐ M 2 反 F 65 Yrs. Director 222-26-8477 MASSACHUSETTS AUG 6, 1940 Usual Residence of Decedent 10c. City. Town or Location 10a State 10b. County 10d. Inside City Limits r than "natural", or itame 23s or 28e-f ehow the Medical Examiner must be notified at 1 ☐ Yes 2 No Director SUSSEX DELAWARE DAGSBORO 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 30974 BUNTING ROAD 19939 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 7 1 ☐ Yes 2 No Specify: Specify: WHITE 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry le markad other than Elementary/Secondary (0-12) College (1-4or 5+) LICENSED PRACTICAL NURSE 12 HEALTH CARE permit. Pages 1 and 2 should be file.
Department of Health and Mental Hy
Importent: If Item 27 Ie markad other
eny Injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be WILLIAM J. WHITTEN ပ္ HILDA MONTONEN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. BOX 438, DAGSBORO, DELAWARE 19939 DAN MATTHEW / EXECUTOR 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State ST. GEORGE'S CEMETERY MAR 8, 2006 CLARKSVILLE, DELAWARE 4 ☐ Donation 5 ☐ Other (Specify) WATSON FUNERAL HOME 211 WASHINGTON ST., MILLSBORO, DELAWARE 19966 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Atherosclerotic Cardiovascular Disease /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner ettending physicien and for use as the burial-transit Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month 4☐Pregnant at time of death 5 Other (specify) P.0. Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ۵ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 ★ Yes 2 □ No Division of Vital 1 Xes 2 No 25. Was case referred to medical example? Be 26. Place of Death (Check only one) Hospital: 1 | Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 □ DOA ٩ 1 ☐ Yes 2 ☐ No this 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Certification: 28d. Describe how injury occurred After Hospital or Attending 5 Pending investigation 1 X Natural death. 1 ☐ Yes 2 ☐ No 2 Accident Director 3 Suicide 6 Could not be 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 | Homicide after within 24 hours a To the Funeral ( 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. March 05, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ANA RUBIO, MD 111 Penn Street, Baltimore, Maryland 21201 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar MAR 0 8 2006

	Pleas	e Type or P	rint in Black Inc	lelible Ink.	Ensure A	II Copies A	Are Legi	ible.			
	_ For	State of	Maryland / Depa					Y, 24		00	
	1 - State Registrar		Cen	tificate of L	Death	Re	g. No. U	16	0//	29	
	1. Decedent's Name (First, Middle,	Last)				2. Date of Death			3. Time of	f Death	
1	Aliyyah Fatima	h Delroba				February	7 22, 2	2006	5:50	рм	
ľ	4a. Facility Name (If not institution,	give street and num	ber)	4b. City, Town, or	Location of Death		4c. County of Death				
	Holy Cross Hos	pital		Silver Spring Mon					tgomery		
	5. Social Security Number 6	6. Sex 7	7. Age (In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth	Voar)	9. Birthp	lace (State	or Foreign	
	None	1□M 211 F	O Yrs.	Months Days	Hours Will.	Feb. 21,	2006	Mar	ÿland		
	Usual Residence of Decedent										
	10a. State 10b. County		10c. City, Town or Loc	ation				1	0d. Inside C	ity Limits	
5	Maryland Montg	omery	Rockville	!					1 🗌 Yes	2 <b>₹</b> No	
0	10e. Street and Number			10f. Zip Code		10	10g. Citizen of What Country?				
	882 College P	ark Way,	Apt. 202	20850 USA							

1 ☐ Yes 2 🖾 No

Never Worked

Decedent's Usual Occupation
 (Give kind of work done during most of working life. DO NOT use retired)

Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

Specify.

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ♣No If Yes, Give

Year or Dates

College (1-4or 5+)

14. Race - American Indian,

Specify.Bi-racial

Black, White, etc.

16b. Kind of Business/Industry

None

18. Mother's Name (First, Middle, Maiden Sumame)

882 College Park Way, Apt. 202, Rockville, MD 20850

Nyein Myint

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28a-f show enjury or other traumatic event, the Medical Examinar must be notified at once.

Completed by Funeral

Be

11. Marital Status

1 Never Married 2 Married

15. Decedent's Education (Specify only highest grade completed)

3 ☐ Widowed 4 ☐ Divorced

Elementary/Secondary (0-12)

17. Father's Name (First, Middle, Last)

Morteza Delroba 19a. Informant's Name/Relationship (Type, Print)

Morteza Delroba/ Father

**Physicia** 

**Funeral** Director

/Medica Examine

**Physician** /Medical Examiner

	20a. Method of Disposition 1 Main Burial 2 □ Cremation 3 □ Removal 4 □ Donation 5 □ Other (Specify)	, cemetery	Disposition (Name of crematory or other place) Heaven Cemetery	February 27 2006		cation - City or er Spri	Town, State .ng, Maryland
	21. Signature of Funeral Service Licensee		22 Name and Address of Fa Francis J. Co 500 University	llins Funer Blvd, W,	al Hor Silve	me Inc r Sprin	g, MD 20901
Physician/Medical Examiner	23a. Lafrt1. Enter the disease, or complications shock, or heart failure. List only one cause Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  C	r arrest,		Approximate Interval Between Onset and Death 1½ Days			
hysician/Med	in the past 12 months?	s, outcome of pregnancy Live birth 2 □ Fetal death Pregnant at time of death Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		- 2	23d. Date of del Month	livery Day Year
ρ	Part II. Other significant conditions contributing	to death but not resulting in	the underlying cause given in Pa		d tobacco u ⊒Yes 21		o the cause of death?
Completed				24a. W au pe 1 🗆 Yes	topsy formed?	death?	utopsy findings available completion of cause of
Be	25. Was case referred to medical examiner?		26. Pla	ace of Death (Check on	y one)		
2	1 ☐ Yes 2 🛣 No Hospital:	1 ☑ Inpatient 2 ☐ ER/Outp	patient 3 DOA Other: 4	Nursing Home 5 ☐ Re	sidence (	6 □Other (Spe	cify)
	2 Accident investigation	Date of Injury (Month, Day Year) 28b. Ti	me of 28c. Injury at work?  M 1 Yes 2	28d. Descrit	e how injur	y occurred	
Certification;	3 Suicide 6 Could not be 4 Homicide determined 28e.	Place of Injury - At home, farr building, etc. (Specify)	m, street, factory, office		(Street and Town, State,		ural Route Number,
edicai	(Check only 2 Medical Exeminer: On	To the best of my knowledge, the basis of examination and manner stated.	death occurred at the time, date /or investigation, in my opinion, o	and place, and due to the time	ne cause(s) e, date and	and manner as place, and due	s stated. e to the cause(s)
Ž	29b. Signature and title of certifier	Compa	D5350	9		e signed (Mont	h, Day, Year) 23, 2006

State Registrar Janel K. HInd, M.D. 1500 Forest Glen Road, Silver Spring, MD 20910

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene AMEND ITEM #3 1- State Registrar 3/3/06 WCHD/SH per Dr. Reg No. U U Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Month Year February Ruth Vivian Dunn 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington County Hospital Hagerstown Washington 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 1 ☐ M 2 💢 F Director 229-34-9620 76 Jan. 20, 1930 West Virginia Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location ir then "natural", or Iteme 23a or 28a-f ehow The Modical Examiner must be notified at 10d. Inside City Limits 1 ☐ Yes 2 No Directo Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10905 Clinton Ave. 21740 U<u>SA</u> 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes A No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2XXVo Specify: ģ 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: if item 27 is marked other then any Injury or other treumatic event, tre Means pines. Elementary/Secondary (0-12) College (1-4or 5+) 12 Clerk Retail 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Boyd LaFollet Mazie Lee McKeever 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10905 Clinton Ave. Hagerstown, Maryland 21740 of Disposition (Name of Date 20c. Location - City or Town, State Wade T. Dunn - Husband 20a. Method of Disposition
1 ☐ Burial 2XX cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Smithsburg Crematory Mar.1,2006 Smithsburg, Maryland 21 Signatur Funeral Se Osborne Home, P.A. 425 S. Conococheague St. Williamsport,MD 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examine ettending physicien and for use as the burial-transit Physician/Medical 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Ves 2 No Month Day 4☐ Pregnant at time of death signed by the et d be detached for 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not cesulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Ď. 2 X No 1 🗌 Yes 3 Probably 4 Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No 24a. Was an has 212 No 1 Yes 25€No 25. Was case referred to dical examiner? 26. Place of Death | Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes No npatient ۴ 2 ER/Outpatient 3□ DOA 27. Manner of Death

1 Augustural
2 Accident 28a. ate of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After Certification: 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No after death 3 🗌 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital -within 24 hours a: To the Funerel D Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical

5H-7

death.

death with the Maryland

filed within 72 hours after

certificate be executed

Division of Vital Records, P.O. Box 68760.

State Registrar

31. Date filed (Month, Day, Year) MAR 0 2 2006

30. Name a a address of person who completed caus

29b. Signature and title of certifier

TUES, COP 32. Registrar's Signature 251 E. Anthetan St

29d. Date signed (Month, Day, Year)

29c. License number

D004113

m.1)

of death (Item 23a) (Type, Print)

		•	1 - For State Registrar Amend #4a pe	State of Mary					giene	6	07731
			Decedent's Name (First, Middle, Last)					2. Date of De.		Year	3. Time of Death
	Physicia /Medic				DAVENPORT	C		Februar			1:10 P M
	Examin	er	4a Facility Name (If not institution, give s	treet and number)		4b. City, Town, or	r Location of D	eath	4c. County		
			<del>2212</del> Sharidan Road	<u>l</u>		Westmi				rol1	
П	Funeral		5. Social Security Number 6. Sex	7. Age (II	yrs. last birthday)	If Under 1 Year Months Days		Min. (Month, Da	ıy, Year)	9. Birtho	place (State or Foreign htry)
	Director	- }	Usual Residence of Decedent		77 Yrs.			NOV. 2	7, 1928	New	Jersey
	and and		10a. State 10b. County	10	C. City, Town or Lo	cation				1	Od. Inside City Limits
	Many -teh	ō	Maryland Carrol	.1	Westn	ninster					1 ☐ Yes 2X No
	the notific	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of \	What Cour	ntry?
	3a o		2212 Sharidan R	Road		21157			United	Stat	ies
	death rma 2	Funerai	11, Marital Status	12. Was Decedent Eve Armed Forces?	r in U.S. 13.	Was Decedent of H	lispanic Origin	? (Specify Yes or No ruerto Rican, etc.)	)- 14. Rac	e Americ	can Indian,
٥	or Its	F	1 Never Married 2 Married	1 XYes 2 No		1 □ Yes 2 No		derio ritodii, oto.,	Specifi	· · · · · · · · · · · · · · · · · · ·	
215-0036	72 hours after death with the Maryland natural', or Itama 23a or 28a-f ehow Sical Examinat must be notified at	d by	3 XWidowed 4 □ Divorced	Year or Dates: 2	3 years					Wni	
ה	nati	Completed	15. Decedent's Educ (Specify only highest grade		(Give	dent's Usual Occup kind of work done o DO NOT use retired	during most of	working	16b. Kind of B	usiness/in	dustry
7	within one.	du	Elementary/Secondary (0-12)	College (1-4or 5+)		itary Car	,		U.S.	Navv	
N	be filed within 72 hours after death with the Marylan Ital Hygiene. Id other than "natural", or Itama 23a or 28a-1 show ovent, it e Medical Examinat must be notified at	ပိ	17. Father's Name (First, Middle, Last)			July July		Name (First, Middle,			
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<u></u>	should I nd Meni n marke umatic	ို	19a. Informant's Name/Relationship (Type			ng Address (Street		or Rural Route Number		State, Zip	Code)
Ξ	d train		Dallas Davenport	/ Daughter	2212	2 Sharida	n Rd./	Westminst	er, Mar	v1and	1 21157
<u>o</u>	s 1 and 2 if Health item 27 other tr		20a. Method of Disposition		20b. Place of Dispo			Date	20c. Location -		
Ë	Pages nent of int: If it	1	1 ☐ Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	Frederick	-		/02/2006	Frederi	ick,M	aryland
altimore, Maryland 21	그 된 원 분 .		21. Signature of Funeral Service License	98	22	2. Name and Addre	ss of Facility	Stauffer	Funeral	Home	s, P.A.
n	Depa Impo any I		Caymond	Telors				Blvd./ Mou			
	Physician /Medical Examiner	_	23a. Part1 Enter the disease, or complishood, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	Due to (or as a co	onsequence of):	bstwo	he j	rulmon	wy di	rease	Approximate Interval Between Onset and Death
,0978	The law requires that the death certificate be executed ate has been signed by the attending physicien and page 2 should be detached for use as the burial-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								
P.O. Box 6	the death certific by the attending plached for use as t	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of p 1 Live birth 2 [ 4 Pregnant at tim 9 Unknown	Fetal death 3	⊒Ectopic pregnancy □ Other <i>(specify)</i>	y			ite of delive	ery Day Year
	n requires that the de been signed by the should be detached	þ	Part II. Other significant conditions con	ntributing to death but n	ot resulting in the u	nderlying cause giv	ven in Part I.		tobacco use con Yes 2 □ No	tribute to t	he cause of death?
II Reco	The law re cate has be page 2 sho	Completed						24a. Was auto perfo 1 Yes	psy	Were auto prior to co death? 1  Yes	opsy findings available impletion of cause of No
ŽĬ.	iician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	lospital:		oth	000	Death (Check only			
Division of Vital Records,	ding Phys h. After this funeral di	ation: To	1 Yes 2 No  27. Man r of Death 1 Natural 5 Pending 2 Accident investigation	1 ☐ Inpatient  28a. Date of Injury (Month, Day Yo	2 ☐ EP/Outpatier 28b. Time o Injury	f 28c. Injur Wor	4 🔲 Nursi		idence 6 Oth how injury occur		'n
Divis	ospital or Attendours after deatl hours after deatl uneral Director: ly filled in by the	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc. (	- At home, farm, sti Specify)	reet, factory, office			(Street and Numl wn, State)	ber or Rura	al Route Number,
	To the Hospital within 24 hours of To the Funeral I completely filled	Medical	(Check on 2 Medical Examination)	sician: To the best of n ner: On the basis of ex and manner stated	amination and/or in	vestigation, in my o	pinion, death	place, and due to the occurred at the time,	date and place,	and due to	o the cause(s)
ı.	5 1× 5 00		29b. Signature and title of certifier	VITOR	MN	29c. Licens		98	29d. Date signe	u (Month,	Cay, rear)
	A.		Mellie M		<b>V</b> • • • • • • • • • • • • • • • • • • •		353		<b>○</b>	1	Up
D	(11,		30. Name and address of person who co	empleted cause of deat	n (Item 23a) (Type,	CP, For	Are,	+ Wast	m17.5+6	y y	1)2/157
ĺ	Sta	te	31. Date filed (Month, Day, Year)	32. Pegistrar's	_				,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	, , ,	
1.2.	Registr		MAR 0 9 20	06 Beare	K A	medi					

			1 - For State Registrar	State of M	laryland	-		nt of H te of L		and M		iene eg. No.	06	0773	12
25	Dhiveisi	` \	1. Decedent's Name (First, Middle, L		76	)	4.6				2. Date of Dea Month	th Day	Year	3. Time of	Death
	Physici /Medio	_	trancis (	harles		Srou					FEBRUARY	7 22,	2006	6:40	A M
	Examin	er	4a. Facility Name (If not institution, g						Location o	of Death			ounty of Deat		
A.	<u> </u>		ANNE ARUNDEL MET 5. Social Security Number 6.		CR ge (In yrs. la:	st birthday)		APOL. r 1 Year	If Under:	24 Hrs.	8. Date of Birth		NE ARU 9. Birtl	NDEL nplace (State o	or Foreign
	Funeral Director		213-30-5042	1 <b>∑</b> M 2□F	74	Yrs.	Months	Days	Hours	Min.	JAN. 7	, Year)	Co.	YLAND	
g	> -		Usual Residence of Decedent		I son City	T								104  ==:4= 0	In . 1 I In .
200	oho a pa	5	10a. State 10b. County			Town or Lo								10d. Inside C 1√2 Yes	2 No
the A	a or 28a-f show	Directo	MARYLAND   ANNE AF  10e. Street and Number	RUNDEL	<i>I</i>	ANNAP(		p Code				0a. Citize	n of What Co		
ž.	3a or		653 BURTON COVE	T WAY				2140					TED ST	,	
death	ma 2	Funerai	11. Marital Status	12. Was Decedent		. 13.	Was Dece			gin? (Spe	crfy Yes or No- Rican, etc.)		Race - Ame Black, White	rican Indian,	
0036 hours after death with the Maryland	il, or itema 23a . Xaminar must b		1 ☐ Never Married 2 🔀 Married	1 XYes 2 ☐ If Yes, Give	No KORI	EAN	1 🗆 Yes		Specify:	, 1 001.0 1	mount, oto.,	S	pecify: WHI		
		ed by	3 Widowed 4 Divorced  15. Decedent's	Year or Dates:	WZIIX	16a. Dece			tion				of Business/		
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ם פ	ai Hy 1 oth vent,	BeC	17. Father's Name (First, Middle, Las	st)					18. Mothe	r's Name	(First, Middle,	Maiden Su	imame)		
<b>Z</b>	Ment	၉	FRANCIS DEBROUSE						MARY						
Maryland	h and 7 Is m traum		19a. Informant's Name/Relationship		1		•				/ Route Number			îp Code)	
	f Healt item 2 other		GLORIA DEBROUSE  20a. Method of Disposition	(WIFE)	. 20b. Pla	653 BU	sition (Na	ime of			NAPOLIS		tion - City or	Town, State	
	0		1 Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spec		*	netery, crei ETERAI				2/27	/2006	CROW	NSVILL	E. MD	
altimore,	Department Important: I any njury o		21. Signature of Funeral Service Lic		, , ,	22	2. Name a	ind Addres	s of Facilit	У	1				
20 8			Sharrow	color	ke tt	- 81	14 BF	STGA	TE RO	AD A	FUNERAL ANNAPOL	IS. M			S
×			23a. Part1. Enter the disease, or co shock, or heart failure. List on	mplications that calls	d he death. lin.	Do not ent	er the mo	de of dying	g, such as	cardiac o	r respiratory arr	est,		Approximat Interval Bet	ween
	nysician		Immediate Cause (Final disease or condition	STARH	AUNE	aus .	MES	HILLIL	LIN	KESL	STANT S	EPS	13	Onset and	745
7/91	Medical xaminer		resulting in death)		s a conseque	ence of):	5	-1 A/O	100	4.5				w 0.	Own C
		ē	Sequentially list conditions, if any, leading to immediate	b. HTPA	s a conseque	ence of):	_	or wa	1000					A DI	131)
peth	d ansit	Examin	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	META	STATI	CA	D EN	OCA	RC W	Um 1	AAL	uN	Si	y Wich	INW.
j Š	sician and burial-trans		resulting in death) Last	Due to (or as	s a conseque								•		
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Heath Can	attend for us	Physician/Me	23b. Was decedent pregnant in the past 12 months?	1☐Live birth 4☐Pregnant a	2 Fetal d	death 3	Ectopic	oregnancy				230	<li>d. Date of deli Month</li>		Year
o g	by the tached	nysid	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9☐ Unknown			3 0 11 10 1 10								
J tett	igned to	by Pi	Part II. Other significant conditions	contributing to death	but not result	ting in the u	nderlying	cause give	en in Part I.		23e. Did to	bacco use	contribute to	the cause of c	death?
	been sig should b										1 🗆 Y	es 2 🗆	No 3□Pro	obably 4	Unknown
ecords,	as be 2 sho	Completed									24a. Was a		24b. Were au	topsy findings	available
		Con									perfor 1 ☐ Yes	med? 2 No	death?	2 🗌 No	
Vital R	us certificate director, pag	Be	25. Was case referred to medical examiner?	Hospital:				Otho			(Check only or	1			
Vision of Vita	this ral dir	. To	1 Yes 2 No 27. Manper of Death	28a. Date of Inj		P/Outpatier 28b. Time o		Othe 28c. Injury	4 🗆 190		ne 5 Resid			cify)	
Ou pi	th. : After this funeral of	tion	1 ✓ Natural 5 ☐ Pending 2 ☐ Accident investigat	(Month, D	ay Year)	Injury	м	Work	k? Yes 2 🗀 I			o, <u>o.</u> .,	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		
	after death.  Director: A  in by the fu	Certification;	3 Suicide 6 Could not 4 Homicide determine	be 28e. Place of Ir		ne, farm, str	reet, facto	ry, office		2	28f. Location (S		Vumber or Ru	ral Route Num	nber.
	al Directed in by	Cert	4   Homicide	bullding, e	etc. (Specify)						City or Tow	n, State)			
]	4 hou Funar lely fill	edical	29a. Certifier 1 Certifying (Check only one)	Physician: To the bes	of examination	ledge, deat on and/or in	h occurre vestigatio	d at the tim	e, date an pinion, dea	d place, a	and due to the c	ause(s) ar	nd manner as lace, and due	stated. to the cause(s	;)
o the	within 2 To the complet	Med	29b. Signature and title of dertifier	and manner s	iaieu.		25	9c. License	number	.1	. 2	9d. Date	signed (Monti	n, Day, Year)	
)	s⊩ő		Amal,	1 AX	tu y				0 21	438	2	Feb		2006	
			30. Name and address of person wh	o completed cause of	death (Item 2	23a) (Type,	Print)						, ,	- 004	<u></u>
			MICHAEL J. LAPEN				HWY	., AN	NAPOI	us,	MD 214	01			
	Sta Registr		31. Date filed (Month, Day, Year)	32. Regis	trar's Signatu		1	<i>M</i> -							
2 .	- registi		FFR 2	4 LUU0 -	Dad . so .	11.	42.3	all I							

			For State	State of Maryland	d / Department of Certificate			2006	07733
	£0. 4		Registrar  1. Decedent's Name (First, Middle, Las	1)	Certificate	or Death	2. Date of Death		3. Time of Death
(A)	Physicia /Medic		Thomas	Den			2 0		0630 AM
	Examin Funeral Director	er	211-52-02111	veral Hospi	tal Berast birthday) If Under 1	Year If Under 24 Hrs. Days Hours Min.	8. Date of Birth (Month, Day, Ye	4c. County of Death  WOFCE  9. Birthy  Coun	5+er place (State or Foreign
	yland now		Usual Residence of Decedent  10a. State 10b. County	10c. City	, Town or Location				10d. Inside City Limits
	the Man 28a-f et	Funeral Director	Md Worce  10e. Street and Number	ster Be	T   10f. Zip C	ode	10g.	Citizen of What Cou	1 Yes 2 No
	23a or	ral DI	113 Flower S	Street Apt. 1	5 21	811		U.S.	Á,
36	ges 1 and 2 should be filed within 72 hours after death with the Maryland to Heatth and Mental Hyglene. If item 27 is marked other than "natural", or Items 23a or 28a-1 ehow or other traumatic event, the Medical Examinar must be notified at	by Fune	11. Marital Status  1 ☐ Never Married 2 1 Married  3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 10 No If Yes, Give / Year or Dates:	13. Was Deceder If Yes, specify	nt of Hispanic Origin? (Spe y Cuban, Mexican, Puerto I No Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ameri- Black, White, Specify: R	
15-00	"natura		15. Decedent's Ed (Specify onfy highest gra	ucation	16a. Decedent's Usual ( (Give kind of work life. DO NOT use	done during most of working	ng 16b	. Kind of Business/In	idustry
212	ed withir ygjene. ner than it, the Ma	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	Porter		C	larion.	Hotel
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumatic event, the Magnee.	To Be	17. Father's Name (First, Middle, Last)  Archie	)ennis		Helen	(First, Middle, Maid	fen Sumame)	
Mary	od 2 sho ith and I 27 is me		19a. Informant's Name/Relationship (1	Type, Print)	19b. Mailing Address (S	Street and Number or Rura	Route Number, Cit	ty or Town, State, Zip	Code)
ore,	Pages 1 ar nent of Hea int: If item?		20a. Method of Disposition 1 △ Burial 2 □ Cremation 3 □	C.C.	ace of Disposition (Name emetery, crematory or othe	of Der place)	Date 20c	. Location - City or To	own, State
altim	permit. Par Departmen Important: any Injury		4 □ Donation 5 □ Other (Specify 21. Sign ture of Funeral Service Licen	0	W Wester	Address of Facility Ben	-06 la	rmichae	LAC.
<u>~</u>	permi Depa Impo any Ir		Muscula	Kninde	P.O. Box	x 331 Pou	omoka (	ity, md	, 2 (85) Approximate
	Physician		23a. Part1. Enter the disease, or comp shock, or heart failure. List only Immediate Cause (Final disease or condition	one cause on each line.		or dying, such as cardiac of	or respiratory arrest,		Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consequ					434/3
	P =	ner	Sacrantially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a consequ	ence of):				
ć.	ate be executed bhysician and the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as a consequ	ence of);				
8760,		dlcall		d					
25/2006 0. Box 6	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use as	Completed by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	23c. If yes, outcome of pregnar 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de 9 □ Unknown	death 3 Ectopic preg			23d. Date of delive	ery Day Year
7 - 2/ 0630 rds, P.	quires that in signed b uld be deta	ed by PI	Part II. Other significant conditions of	ontributing to death but not resu	lting in the underlying cau	ise given in Part I.	23e. Did tobacc	co use contribute to t	
$8/18/1447$ $\sim 00$ Vital Records,	The law re ate has bee page 2 sho	Somplet					24a. Was an autopsy performed	24b. Were autoprior to codeath? No 1 Yes	opsy findings available ompletion of cause of
%/ Vita	Physician: this certificand in this certificand in the certificand in	Be	25. Was case referred to medical examiner? 1 Yes 2 □ No	Hospital: 1 Mainpatient 2 □ I	-0.0	26. Place of Death	Check only one		
14.5 17.0 11.0f	ng Phya fter this ineral di	on: To	27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day Year)	ER/Outpatient 3 DOA 28b. Time of Injury 28c		me 5 Hesidence 28d. Describe how in		<u>y)</u>
s, Thomas 52-0271 Division o	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined		me, farm, street, factory, o	1 Yes 2 No	28f. Location (Street City or Town, St	and Number or Rur. tate)	al Route Number,
Dennis, 217-52 Di	Hospital	Medical Ce	29a. Certifier 11 Certifying Ph (Check only one)	ysicien: To the best of my knowniner: On the basis of examinat	vledge, death occurred at ion and/or investigation, in	the time, date and place, and my opinion, death occurr	and due to the cause ed at the time, date	e(s) and manner as s and place, and due t	stated. o the cause(s)
22	To the within 2 To the complet	Med	29b. Signature and title of centifier	and manner stated.		License number		Date signed (Month,	
			20 Name and	completed cause of death (free	23a) (Typo Bries)	005082	6	2/25/0	6
3	ET3		RAZAAK A.	completed cause of death (Item ENIOLA	1733 HEACI	TH-WAY DR	BENLIN	mp 21	811
	Sta Registi		31. Date filed (Month, Day, Year) FEP 2 8 20	32 egistrar's Signat	* Specker				

			1- State Registrar Amend Item 26 aper Manual Registrar	Py14756 Health and Mertificate of Death		ne .2006	07731
	Physici		Decedent's Name (First, Middle, Last)     THE LMA     DeHAVEN		2. Date of Death Month FEB. 24,	Day Year 2006	3. Time of Death 5:58 A
	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	1 2 2 7 5	4c. County of Death	J.30 A
	Funeval		SOMERFORD ASSISTED LIVING  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	HAGERSTOWN  If Under 1 Year If Under 24 Hrs.	8. Date of Birth	WASHI 9. Birtho	NGTON lace (State or Foreign
1	Funeral Director		234-38-7567 1 M 2 T 80 Yrs.	Months Days Hours Min.	5/16/192	5 WEST	try)
	yland now		Usual Residence of Decedent           10a. State         10b. County         10c. City, Town or U	ocation	·	1	Od. Inside City Limits
	Ba-1sh	ctor	WV BERKELEY	MARTINSBURG			1 Y Yes 2 □ No
	be filed within 72 hours after death with the Maryland that Hygiene. ad other than "natural", or Itams 23a or 28a-1 show event, I've Medical Examination that the indifficulation.	Funeral Director	10e. Street and Number 603 FOXCROFT AVE. APT. 2P	10f. Zip Code 25401	10g	. Citizen of What Cour USA	itry?
	er deat	unera	11. Marital Status 12. Was Decedent Ever in U.S. 13 Armed Forces?	Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White,	
036	ours aft	by	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 (10)No HYes, Give Year or Dates:	1 ☐ Yes 2 No Specify:		Specify: W	HITE
21215-0036	n 72 ho "natur	Completed	(Specify only highest grade completed) (Giv	edent's Usual Occupation e kind of work done during most of worki DO NOT use retired)		b. Kind of Business/Inc A MEDICAL	dustry
212	filed withi Hygiene. other than	Somp	Elementary/Secondary (0-12) College (1-4or 5+)	COMPTROLLER		CENTE	R
Maryland	be de de	Be	17. Father's Name (First, Middle, Last)  ALLEN FOX		(First, Middle, Ma. LOUISE		
ary	s 1 and 2 should be f Health and Mental itam 27 is markad c other traumatic eve	2		ling Address (Street and Number or Rura			Code)
	1 and Health am 27 ther tr		DIANE D. BROWN/DAUGHTER 118  20a. Method of Disposition 20b. Place of Disp	GROVE ST., #25, ST		CT 06901 c. Location - City or To	wn State
mor	0 0		1 🕅 Aurial 2 Cremation 3 Removal from State PETASANT	<b>VIEW</b> MEMOR <del>Y</del> <sup>®</sup>   FEBRU	JARY 2006	MARTINSBURG,	
Baltimore,	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service Licensee Chaules m. Blown	327 W. KING 25402			
	×		23a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.	1			Approximate Interval Between Onset and Death
	Prrysician /Medical		Immediate Cause (Final disease or condition resulting in death)  a	elerofic D	eman	tra	Years
	Examiner		Sequentially list conditions, b.				
	uted d ansit	Examiner	if any, leading to immediate causs. Enter Underlying Cause (Disease or injury that initiated events				
90,	cate be executed physician and the burial-transit	i Exa	resulting in death) Last Due to (or as a consequence of):				
68760		edicai	d				
Вох	death certifi e attending id for use as	Physician/Me		□Ectopic pregnancy □ Other (specify)		23d. Date of delive Month	ry Day Year
P.0	that the de ned by the detached	Phys	9 Unknown  Part II. Dther significant conditions contributing to depath but not resulting in the	underbing cause guren in Dect I	220 Did tobas	co use contribute to the	a course of death?
rds,	sign sign	d by	Hypertipulama	underlying cause given in Parci.	1 🗆 Yes	/	ably 4 Unknown
Record	law requas been 2 should	Completed	0, ,		24a. Was an autopsy		osy findings available inpletion of cause of
<u>a</u>		е Соп	25. Was case referred to medical			d3 death?	210 No
of Vital	ys dis	To Be	examiner?  1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatie	26. Place of Death ont 3 DOA Other: 4 Nursing Hor	me 5 Residenc	e 6 Other (Specify	Assisted
	ng fter ine	tion:	27. Manner of Death  1 Natural 5 Pending (Month, Day Year)  2 Nacidant investigation  28a. Date of Injury (Month, Day Year)	of 28c. Injury at Work?  M 1 □ Yes 2 □ No	28d. Describe how	injury occurred I	iving
Division	al or Attanding s after death. I Diractor: After od in by the fune	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)		28f. Location (Stree City or Town, S	at and Number or Rura	l Route Number,
ā	To the Hospitel or, within 24 hours after To the Funeral Direction Completely filled in b.		29a. Certifier 12 Certifying Physician: To the best of my knowledge, dea	th conversed at the time data and allow			
	Fo the Hospital within 24 hours a Fo the Funeral I completely filled	Medical	(Check only one)  2 Medical Examiner: On the lasis of examination and/or i and mariner stated.	nvestigation, in my opinion, death occurr	ed at the time, date	and place, and due to	the cause(s)
	To t To t com	Σ	29b. Signature and the of certifier	29c. License number	1250 29d.	Date signed (Month, I	Day, Year)
	7.1		30. Name and address of person who completed cause of death (Item 23a) (Type	000 568 9 St. Paul St.		1	
	4		William F. Bolenberner, MO  31. Date filed (Month, Day, Year)  32. Registrar's Signature	9 St. Paul St.	Boons	ppopola, m	0 21713
**	Sta Registr		MAR 1 4 2006				

			For State Registrar		State of	of Mary			ment of H <i>licate of L</i>	ealth and Death	Men		enė	UU6	0//30	)
			Decedent's Name	e (First, Middle, La	st)							Date of Death	1		3. Time of Death	
	Physici		GLADYS DORE	EN FITZGER	ALD							Month BRUARY	Day 22 2	Year 006	1:50 A	М
)	/Medic Examin		4a. Facility Name (/			umber)		46	o. City, Town, or	Location of Deat			_	ounty of Death		
	Exami		HOLY CROSS	HOSPITAL				ST	LVER SPRI	ING			MON'	TGOMERY		
	Funeral		5. Social Security N		Sex	7. Age (In	yrs. last birth	day) If	Under 1 Year	If Under 24 Hrs		Date of Birth			place (State or Foreig	gn
	Director		213-28-5303		I		79 Y	rs. M	onths Days	Hours Min.		Month, Day, RCH 15,				
ш.			Usual Residence of													
	anylan show		10a. State	10b. County		10	c. City, Town	or Locati	on						10d. Inside City Limit	
	May May	ğ	MARYLAND	MONTGOMER	ď	S	ILVER SE	RING							1 ☐ Yes 2 🖾 N	0
	r 28	Director	10e. Street and Nu	mber				1	10f. Zip Code			10	g. Citize	n of What Co	untry?	
	h wit	ai D	11637 LOCKW	OOD DRIVE					20904				U	.S.A.		
	deed str	Funerai	11. Marital Status		12. Was Dec	edent Ever	in U.S.	13. Was	Decedent of Hi	spanic Origin? (S n, Mexican, Puer	Specify	Yes or No-	14.	. Race - Amer Black, White		
9	or Its	2	1 Never Marr	ied 2□ Married		2 🔯 No			Yes 2 No	Specify:	tornoa	11, 6(0.)			s, etc.	
21215-0036	within 72 hours after deeth with the Maryland ene. than "natural", or Items 23e or 28e-f show the Madical Exeminer must be notified at	1 by	3 🖾 Widowed	4 Divorced	Year or I	Dates:		10	162 5120140	Specify.			3)	рес <i>ify</i> : WH	ITE	
5-0	72 h	Completed	(Spec	15. Decedent's E		)	16a. [	Decedent Give kind	's Usual Occupa d of work done o	ation <i>Juring</i> most of wo )	rking	1	6b. Kind	of Business/I	ndustry	
21	ithin	id u	Elementary/Seco			(1-4or 5+)		life. DO	NOT use retired,	)		I	NFORM	ATION MA	NAGEMENT	
2	ygier ygier yer th	Ö	8				SECE	ETARY	<u></u>				YSTEM			
pu	tal H d oth	Be	17. Father's Name							18. Mother's Na	me (Fir	st, Middle, N	taiden Si	umame)		
yla	Men Arks arks	၉	STEPHEN GEO							ELEANOR						
Maryland	and and is m		19a. Informant's N	ame/Relationship (	Type, Print)		19b.	Mailing A	ddress (Street a	ind Number or R	ural Ro	ute Number,	City or T	own, State, Z	ip Code)	
<u>.</u>	and ealth m 27		STEPHEN S.		/SON					LAUREL,						- 1
ore	S P E S P		20a. Method of Dis	position ⊠Cremation 3 [	Removal from		Ob. Place of I cemetery	) isposition, cremato	on (Name of ory or other place	9)	Date	2	20c. Loca	tion - City or 1	lown, State	
Ě	Pag ment Mr. I			5 Other (Speci			FORT LIN	COLN	CREMATORY	02/2	8/20	06 B	RENTW	OOD, MAR	YLAND	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryla Deperment of Health and Menfal Hygiens. Important: If Item 27 is marked other than "natural", or itsma 23a or 28a-1 show important: If Item 27 is marked other than "natural", or lisma 23a or 28a-1 show in propriet or other traumatic event, the Madical Exemples must be notified at once.		21. Signature of Fu	ineral Service Lice	nsee			22. No	ame and Addres	s of Facility FUNERAL	TUME	TNC				
<b>m</b>	g ⊊ ≅ 9		Uma	nda	Zude	wo	/	1180	O NEW HAM	IPSHIRE AV	ENUE	, SILVE	R SPR	ING, MAR	YLAND 20904	
			23a. Part1. Enter t	he disease, or con	plications that	caused he	death. Do no	ot enter th	he mode of dying	g, such as cardia	c or res	spiratory arre	st,		Approximate Interval Between	
	Physician		Immediate Cause disease or condition	(Final		CANCER									Onset and Death	
j	/Medical		resulting in death)	•	a		insequence of	f):		-						-
	Examiner				_											
		je	Sequentially list co	inditions, inmediate	b. Due to	o (or as a co	nsequence of	f):								
	cate be executed physicien and the burial-transit	Examiner	cause. Enter Under Cause (Disease or that initiated events	injury	c.											
ó	exection and and rial-tr	EX	resulting in death)	Last		o (or as a co	nsequence of	f):								
68760,	ysicie	dical			d											
													-1		**	-
Вох	death certifica ettending ph of for use as t	2	IF FEMALE: 23b. Was deceden		23c. If yes, or		regnancy Fetal death	2 🗆 E at	topic pregnancy				230	d. Date of deli	very	
	law requires that the death certif as been signed by the ettending 2 should be detached for use as	Physician/M	in the past 12		4□Preg	nant at time			ther (specify)					Month	Day Year	
P.0	that the de ned by the e detached f	h	9 🗆 Unknown		9□ Unki	nown					_					-
	signed I	by P	Part II. Other signi	ficant conditions	contributing to	death but no	ot resulting in	the unde	rlying cause give	en in Part I.		23e. Did tob	acco use	contribute to	the cause of death?	
ğ	quire in sig uld b	B										1 □ Ye	s 2 🗆 i	No 3 □ Pro	obably 4 ∰Unknow	m
Records,	w require been signature	Completed										24a. Was ar	1 :	24b. Were au	topsy findings availab completion of cause of	ole
Re	The la ate has page 2	m/C										autops	red?	death?		ŀ
	n: T ifficati or, pa	ပိ	25. Was case refer	red to medical						OC Blace of Do		1 ☐ Yes 2		1 🗆 Yes	2□ No	
of Vital	Physician: this certificatal director, p	00	examiner?		Hospital:	Innationt	2 🖾 ER/Out	ationt	3□ DOA Othe	26. Place of De er: 4 ☐ Nursing I				Other (Care	.40	
of	Phy rahis	5	27. Manner of Deat		28a. Date	of Injury	28b. Ti		3LI DOA	4 Li Nuising i	-,	Describe ho			ary)	
on	Attending r death. sctor: After by the fune	tio	1 XNatural	5 Pending investigation	(Moi	nth, Day Ye		jury	28c. Injury Work	k? Yes 2 ∐ No						
S	deat deat ctor: y the	lica	2 ☐ Accident 3 ☐ Suicide	6 Could not be	00 - 01-	e of Injury -	- At home, far	m. street.	factory, office		28f.	Location (Str	reet and t	Number or Ru	ral Route Number,	
Division	or after Dirs	Certification;	4  Homicide	determined	build	ding, etc. (S	Specify)	,	identify; direct			City or Town			,	
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2		29a. Certifier	1 X Certifying P	nvsician: To th	ne best of m	v knowledae	death on	courred at the tim	ne date and plac	e. and	due to the ca	use(s) ar	nd manner as	stated.	
	24 h	Medicai	(Check only one)	2 ☐ Medical Exa	miner: On the	basis of exa	amination and	or invest	tigation, in my op	oinion, death occ	urred a	t the time, da	ite and pl	lace, and due	to the cause(s)	
	To the within 2 To the comple	Me	29b. Signature and	title of certains	18				29c. License	number		29	d. Date :	signed (Montt	n, Day, Year)	
	ſ			e_	11	Mo			D 2	1348				07	. 22. 200	6
	9		30. Name and add	race of core as un	completed as	use of don't	/ltem 22a\ /	Tune Date								
										THE MADVE	T A NTD	20010				
	Sta	to	STEVEN GRUF 31. Date filed (Mor							TIAKI	PHIAD	703T0				
	Regist			FEB 28	2006	A BOAR	Signature	6500	ME							

			for Amend Ite	n 26 State	of N	larylar rb.,G	853 <b>,</b> 63	714/06 rtificate	ahb of L	ealth a D <i>eath</i>	and M	lental Hy	giene Reg. No.		5 (	17737	
	Physici	K e	1. Decedent's Name (First, Middle	e, Last)								2. Date of De Month	ath Day		Year	3. Time of Death	
	/Medic		Barbara	June		nch						Marcl			006	5:00 aMm	Ω
	Examin	er	4a. Facility Name (If not institution	_						Location o	of Death			County			
			12706 Nort	h Clit			last birthday)	Bowi If Under 1		ID If Under 2	24 Hrs.	8. Date of Bir		inc		eorge ace (State or Foreign	
	Funeral Director		578-44-8989	1 □ M 2 및		71	Yrs.		Days	Hours	Min.	(Month, Da May 1	7. Year)	34	Coun	rland	
SERVE.			Usual Residence of Decedent														_
	irylan ihow	_	10a. State 10b. County			10c. Ci	ity, Town or Lo	ocation							10	0d. Inside City Limits 1 ☐ Yes 2 ☑ No	
	8a-f.	Director		morela	nd	На	igue										_
	with th	늠	10e. Street and Number	_		_		10f. Zip C							hat Coun	try?	
	eath v	erai	W1 11 11. Marital Status	ton Far		oad t Ever in U	IS 13	224		snanic Orio	nin? (Sne	ecify Yes or No	US		- America	an Indian,	_
	hours after death with the Maryland tursi, or items 23s or 28s-f show at Exertinet freet by rutilised at	Funeral	1 Never Married 2 Mar	Arme	d Forces	?		If Yes, specif	fy Cuba	n, Mexican	, Puerto	Rican, etc.)		Black	c, White, e	etc.	
036	urs at	by	3 ☐ Widowed 4 ☐ Divorced	If Yes Year	es 2 K Give or Dates	:		1 ☐ Yes 2	₹ No	Specify:				Specify:	Whit	ce	
2-0	n 72 hours after death with the Marylan "natural", or Items 23s or 28s-f show lodical East Liverrunt be notified at	Completed	15. Deceden (Specify only highe	it's Education	ted)		(Give	dent's Usual	c done a	turina most	of works	na	16b. Kii	nd of Bu	siness/Ind	lustry	
2	d within piene. r than "	npidu	Elementary/Secondary (0-12)	<del></del>	ge (1-4o	5+)		DO NOT use	_					_		_	
121			12 17. Father's Name (First, Middle,	l astl			H	ome m	nake		r's Name	(First, Middle			mplo	oyed	
and	be de la la la la la la la la la la la la la	o Be	Henry Tucker		a												
Maryland 21215-0036	Should No.	Ĕ	19a. Informant's Name/Relations				19b. Maili	ng Address (	(Street a			le Mary			7.77	Code)	
<b>S</b>	nd 2 state at 127 in r treu		April Carroll	l (dauc	hte	r)	1270	6 Nor	th	Clif	ff R	load, Bo	owie	М	arv]	and	
ē,	s 1 a f Hea item othe		20a. Method of Disposition		184	20b.	Place of Dispo	sition (Name	e of		- 0	Date			City or To		-
Ë	Pages nent of int: if it		1 Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S		rom Stati	°  Ca	rmel	Unite	ed M	íeth.	3/	6/06	Hag	ue,	VA		
Baltimore,	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service			CC		2. Name and Welch			-	1. lome Mo	7546 ontr	Ki oss	ngsH ,VA	Iwy 22520	
\$			23a. Part1. Enter the disease, or shock, or heart failure. List	complications to	nat cause on each	d the dea										Approximate Interval Between	
	Physician		Immediate Cause (Final disease or condition	3	Ca	edec	ie 9	tonyl	ton	lia						Onset and Death	
	/Medical Examiner		resulting in death)	Du	to (or a	s a conse	quence of):	(									
Sec	Lxammet	_	Sequentially list conditions,	b	h [	s a cunsed											_
	led Isit	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	<	o to (or a	a a conse	qualities on.										
•	xecul and al-trar	Examine	that initiated events resulting in death) Last	c.	e to (or a	s a consec	quence of):						-		=		
8760,	death certificate be executed e attending physicien and id for use as the buriat-transit	ical															
687	ificate g phy as the	ed		0.									- 1				
Вох	death certifica attending ph d for use as ti	Physician/M	IF FEMALE: 23b. Was decedent pregnant			e of pregn 2  Feta		Ectopic pre	Chancy				2		of delive	•	
	deat	slcia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4□F		at time of		Other (spec						Mon	th	Day Year	ľ
P.0	ires that the de signed by the a t be detached f	Phy	9 Unknown									an- Did.			b		and a
	signed	by	Part II. Other significant condition	ons contributing	to death	but not re	sulting in the u	inderlying cat	use give	n in Part I.			obacco u /es 2[	_	bute to th 3 ∏ Proba	e cause of death?	
oro	requ een	sted		V 40300	<u>u</u>	K		<del>an</del>						1			_
Vital Records,	The lar ate has page 2	Completed									_	24a. Was autop perfo	rmed?	d d	nor to con eath?	osy findings available apletion of cause of 2 No	
Vita	Physician: this certific ral director,	Be	25: Was case referred to medica examiner?	Hospital:	Same - make	ion + Net			Othe	1	4	Check my c		grante as		aughters Home	
o	Phys rthis ral dia	1	1 Yes 2 No  27. Manger of Death		l 🗌 Inpat ate of In		ER/Outpaties 28b. Time o			4   Nu		me 5 Residence Residence Residence Section Residence Res				11400	-
O	ding th. th. : After stuner	ţ	Natural 5 Pendir	ng (	Month, D	ay Year)	Injury	м	lc. Injury Work	:? Yes 2 □ l	No						
Division	Attending or death.	ifica	3 Suicide 6 Could 4 Homicide	not be 28e. F			iome, farm, st	reet, factory,	office						r or Rural	Route Number,	-
Ö	s afte	Certification:	4   Homicide		uliaing, e	etc. (Speci	'ry)					City or To	vn, state)				
	To the Hospitel or Atten within 24 hours after deat To the Funeral Director: completely filled in by the	edicai (	29a. Certifier   Certifyin (Check only one)   Certifyin	g Physician: To Examiner: On to and	the bes ne basis manner s	of examina	owledge, deat ation and/or in	h occurred at vestigation, i	t the tim in my op	e, date and pinion, deat	d place, a	and due to the ed at the time,	cause(s) date and	and mar place, a	ner as sta nd due to	ated. the cause(s)	
	To the To the Comp	ž	29b. Signature and title of certifie	1					~	number	20			-		Day, Year)	
)			/~ )	1	_				NE	5702	-8		3	.3	-06	7	
			30. Name and address of person	who completed	600	death (Ite	m 23a) (Type,	Print) # 2	131	Ann	abo	M ail	D '	214	-00 01		
# .	Sta	_	31. Date filed (Month, Day, Year)	1	2. Regis	trar's Sign	ature										
	Registr	ar	MAR 1 4 2006	1000	1	er L	TOME										

			State of Maryland / Department	artment of H			ne o	07738
	Physicia	an.	Decedent's Name (First, Middle, Last)			2. Date of Death		3. Time of Death
	/Medic		Richard Alan Ganzman	# 0's T	t and a start	March	1 20	
	Examin	er	4a. Facility Name (If not institution, give street and number) Union Hospital	Elkton	Location of Deat	1	4c. County of D	Death •
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.		9.	Birthplace (State or Foreign
	Director		218-52-4279 <sup>1</sup> ∑ <sup>M</sup> <sup>2</sup> □ F 54 Yrs.	Months Days	Hours Min.	OCT 23,	951	Maryland
	and		Usual Residence of Decedent           10a. State         10b. County         10c. City, Town or Lo.	cation				10d. Inside City Limits
	Maryla f sho	10	Maryland Cecil Elkton					1 ∑Yes 2 □ No
	r 28a-	Director	10e. Street and Number	10f. Zip Code		10g	. Citizen of Wha	t Country?
	th with	al D	110 White Hall Road	21921			United	States
	r dea	Funeral	Armed Forces?	Was Decedent of Hi f Yes, specify Cuba	ispanic Origin? (S in, Mexican, Puer	pecify Yes or No- o Rican, etc.)		American Indian, Vhite, etc.
36	72 hours after death with the Maryland 'naturel', or Itams 23a or 28a-f show dical Examinar must be notified at	by Fi	1 ☐ Never Married 2 🕅 Married 1 ☐ Yes 2 🕅 No If Yes, Give 1 3 ☐ Widowed 4 ☐ Divorced Year or Dates:	I∐Yes 2∭X No	Specify:		Specify:	White
9	2 hour	led t	15. Decedent's Education 16a, Deced	lent's Usual Occupa	ation	16	b. Kind of Busin	
215	thin 7:	Completed	(Specify only highest grade completed) (Give life. L	kind of work done of OO NOT use retired	during most of wo	rking		
7	ed wil	Con	12 Lat	orer				nstruction
and	ntal H ad ott	Be	17. Father's Name (First, Middle, Last)			ne (First, Middle, Ma		
Ž	should nd Me mark matic	우	Leonard Harvey Ganzman  19a. Informant's Name/Relationship (Type, Print)  19b. Mailin	ng Address (Street a		n Vera Bai ural Route Number, C		te, Zip Code)
S	nd 2 salth ar 27 is r trau		Mary L. Ganzman/Wife 110	White Hal	1 Road,	Elkton, M	aryland	21921
ore,	es 1 a of Hei		20a. Method of Disposition  1				c. Location - City	
Ē	Page ment ant; it ury o		'4 Donation 5 Dotner (Specify)   Methodist	t Cemeter	y 2006	C1	nerry Hi	11, Maryland
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic avant. If a Modical Examination to notified at once.	F. 19	21. Signal tre of Funeral Service Licensee Hi	Name and Address LCKS Home )3 W. Sto	ss of Facility for Fun <u>ckton St</u>	erals, P. <i>R</i> reet, Elkt	on, Mar	yland 21921
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter	er the mode of dyin	g, such as cardia	or respiratory arrest		Approximate Interval Between Onset and Death
	Pnysician	i y	Immediate Cause (Final disease or condition resulting in death)	LANCE	The			0.130t and 2021.
	/Medical Examiner		Immediate Cause (Final disease or condition resulting in death)  a	MOPAT	n+u 1	CHF		
		Jer	if any, leading to immediate Due to (or as a consequence of).	10//	1 1	-117		1000
J	cuted nd ransit	Examine	cause, Enter Underlying Cause (Disease or injury that initiated events c			. <del></del>		
8760,	cate be executed physician and the burial-transit		resulting in death) Last Due to (or as a consequence of):					
	death certificate be executed e attending physician and id for use as the burial-transi	dlcal	d					
9 x	death certifica attending ph d for use as ti	Physician/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy				23d. Date of	delivery
Box	death e atter d for u	iciar	in the past 12 months?  1 Ves 2 No 4 Pregnant at time of death 5	Ectopic pregnancy Other (specify)			Month	Day Year
P.0	t the by th tache	hys	9 Unknown					
Ś	be g	by	Part II. Other significant conditions contributing to death but not resulting in the ur	nderlying cause give	en in Part I.			te to the cause of death?
orc	requ gen houk	eted						
of Vital Record	e lav has je 2	Completed			<del></del>	24a. Was an autopsy performe	prior	
/ita	sician: Th certificate rector, pag	Be (	25. Was case referred to medical examiner?			ath (Check only one)		
of \	8 v T	T.	1 Ves 2 No Hospital: 1 Inpatient 2 Pr/Outpatien  27. Manger of Death 28a. Date of Injury 28b. Time of		4   Nursing F	lome 5 ☐ Residence 28d. Describe how		Specify)
	ding h. After fune	tlon	1 Natural 5 Pending (Month, Day Year) Injury	Worl	yat k? Yes 2 □ No	20d. Describe now	mijury occurred	
Division	Il or Attending after death. Diractor: After d in by the fune	ertification:	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, str			28f. Location (Street	et and Number o	or Rural Route Number,
Ö	Dir	Cert	4 ☐ Homicide determined building, etc. (Specify)			City or Town,	state)	
	To the Hospital or Attenwihin 24 hours after deat To the Funeral Director: completely filled in by the	ledical	29a. Certifier  (Check only one)  1 Certifying Physician: To the best of my knowledge, death of the basis of examination and/or invariant manner stated.	occurred at the time vestigation, in my of	ne, date and place pinion, death occu	e, and due to the causurred at the time, date	se(s) and manne and place, and	or as stated. due to the cause(s)
)	To the within to the complex c	×	29b. Signature and little of certifier Ac Dillen,	M ).	DZZ	647 m	Date signed (M	2, 2006
	9		30. Name and address of person who completed cause of Seath (Item 23a) (Type, PATRICIA A. DILLEN	Print) M.D	Union	Hospital ow St., El	kton, M	D 21921
	Sta Registr		31. Date filed (Month, Day, Year)  MAR 1 4 2005  32.Registrar's Signature	all a				

DHMH 17 Rev 1/2001

ORIGINAL

			For State Registrar	State	of Marylar			nt of Hea te of De		Mental Hy	giene Reg. No.	)06	07739	)
¥ ¥ F	Physici	an	1. Decedent's Name (First, Middle CATHERI)		ILBE	RT				2. Date of De Month	ath Day	ZOCL	3. Time of Death	h 4M
	/Medio		4a. Facility Name (If not institution			121	4b. City	Town, or Loc	ation of Deatl			ounty of Death		_
K.S.		1	Lorien Rehab					lumbia				loward		
	uneral rector		5. Social Security Number 577.26.3896	6. Sex 1 ☐ M 21∑ F	7. Age (In yrs. 83	last birthday) Yrs.	Months		Jnder 24 Hrs. ours Min.	8. Date of Bir (Month, Da	y, Year)	9. Birthp Coun 2 Mary	ace (State or Fore	эigп
	·		Usual Residence of Decedent		0.5					Nov. 4	, 194	z mary.	Land	
death with the Maryland	show	۰	10a. State 10b. County			ity, Town or Lo	ocation					1	0d. Inside City Lim 1 ☑ Yes 2 ☐	
he M	28a-f	Directo	Maryland Howa	rd		Dayton	101.7	- Code			10= 00=			INO
with t	Sa or 2		15025 Oak Ridg	re Court				00de 1036			U.S	en of What Coun	iry :	
death	ms 23	Funerai	11. Marital Status	12. Was Dec	cedent Ever in U	J.S. 13.			nic Origin? (S	pecify Yes or No o Rican, etc.)		. Race - Americ		
OU36	or its	y Fu	1 ☐ Never Married 2 ☒ Married	If Yes, G	2⊠No live		nires,spe 1⊡ Yes		oecify:	o Hican, etc.)		Black, White, pecify:Blac		
Single Single	"natural", or items 23a or 28a-f show ofical Examiner must be notified at	ed by	3 Widowed 4 Divorced	Year or I	Dates:							of Business/Inc		
<b>.</b> 7 ci	n na	piet	(Specify only highe	it's Education st grade completed		(Give	kind of w	al Occupation ork done during se retired)	g most of wor	rking	100. Kind	or business/inc	lustry	
d 21215 filed within 72 Hygiene.	and and	Completed	Elementary/Secondary (0-12)	2 Year	(1-4or 5+) S	Aı	nalys	t			U.S.	. Govern	ment	
E 8 8	d other event, II	Be	17. Father's Name (First, Middle,	Last)						ne (First, Middle,	, Maiden S	umame)		
aryia should		P L	Willie Green  19a. Informant's Name/Relations			10h Marili	Add		ora A	. Young		Town Cases Tim	Codel	
Man d 2 st ith and	27 is n treun		Karen R. Gilbe		daughte		•	•					,	
re, N s 1 and f Health	item o		20a. Method of Disposition		20b. i	Place of Dispo			1	Date		ation - City or To		
Pages	1 50		1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S		1 State	rklawn			02/2	7/2006	Rocky	ville, M	aryland	
<b>Baltimore,</b> permit. Pages 1 au Department of Hea	Important: If Item 27 is marke sny injury or other treumatic once.		21. Signature of Funeral Service	Licersee _	4.	H	Name a	nd Address of	Faculty I FUNE	RAL HOME	E. INC	G.		
M % & &	.= % a		Many A	. Ve aen	- Cu	1	1800	New Har	mpshir	e Ave, S	Silver		, MD 209	04
			23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final										Approximate Interval Between Onset and Death	
france .	sician edical		disease or condition resulting in death)		O (or as a consec		ructi	ve pu	umona	cry dis	rase		ten yea	43
Exa	miner		0	h	7 (01 43 4 0011300	<b>440</b> 1100 01).								
Q	Ħ	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to	(or as a consec	quence of):								
cecute	and I-trans	Examine	that initiated events resulting in death) Last	c	o (or as a consec	Tuence of):								
I <b>RECORDS, P.O. BOX 68/6U,</b> The law requires that the death certificate be executed	physicien and the burial-transit	dicai E			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,								
587 tifficate		ledic		J										
BOX	igned by the attending be detached for use es	Completed by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?		utcome of pregnation		Ectopic p	regnancy		NIA	23	d. Date of delive	2	
C. It	the at	ysici	1 ☐ Yes 2 10 No 9 ☐ Unknown		nant at time of c	death 5	Other (s	pecify)				MOHUI	Day Year	
, in the second	ed by detac	/ Ph	Part II. Other significant condition	ons contributing to	death but not res	sulting in the u	nderlying	ause given in	Part I.	23e. Did t	obacco use	e contribute to th	e cause of death?	,
rds quires	n sign	q pe	Dement	ia				7-12		136	Yes 2□	No 3 Prob	ably 4 🗆 Unkno	wn.
O M	s been si 2 should b	piet	Hyperten	sion						24a. Was	an	24b. Were autop	osy findings availa	able
	certificete has irector, page 2	Com								perfo	rmed?	death?	2 No	OI .
VITA ician:	ector,	Be	25. Was case referred to medica examiner?	Hospital:				Other		ath (Check only o				
Phys	rthis raldir	. To	1 Yes 2 No 27, Manner of Death	28a. Date		ER/Outpatier 28b. Time o		28c. Injury at	Nursing H	lome 5 Resident			)	
On ding	: Afte	tion	1 XNatural 5 ☐ Pendir	/1/0	nth, Day Year)	Injury	м	Work? 1 ☐ Yes	2 🗆 No					
DIVISION OF I or Attending Phy after death.	by th	Certification	3 Suicide 6 Could 4 Homicide determ	nined 286. Plac	e of Injury - At h	iome, farm, sti	eet, factor	y, office		28f. Location (: City or To	Street and	Number or Rura	Route Number,	
vital or	To the Funerel Director: Atter this certifical completely filled in by the funeral director, i													
Hosp 24 ho	Fune stely fi	Medicai	29a. Certifier 1 Certifyir (Check only one) 1 Medical	ng Physician: To the Examiner: On the	te best of my kno basis of examina nner stated	owledge, deat ation and/or in	h occurred vestigation	l at the time, d n, in my opinio	ate and place n, death occu	e, and due to the erred at the time,	cause(s) a date and p	nd manner as st lace, and due to	ated. the cause(s)	
To the	To the	Me	29b. Signature and title of certifie	· h	Juliou.		29	c. License nur	mber		29d. Date	signed (Month,	Day, Year)	
4			•	1/1	N	$1, D_i$		256	531		Fet	22,	2006	
			30. Name and address of person	who completed car	use of death (Iter	m 23a) (Type,	Print)	c.1.	. 1	o, and due to the tried at the time,	2104	14		
- Care - 12	Sta	to	Harry Li, 1 31. Date filed (Month, Day, Year)	0780 Hic	Registrar's Sions	ature /	< a,	Colu	in dic	., IVID	3107	7		
	ات Registr		FEB 28	2006	ance A	G. AD	and I							

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Leo Charles GOREN Month February 25, 2006 2:50 P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Liberty Assisted Living Potomac Montgomery If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Director 17 1917 377-03-2768 88 Michigan Aug. Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland 10a State 10c. City, Town or Location 10d. Inside City Limits 10b. County "natural", or items 23a or 28a-f show edical Exercites cast be notified at 1 ☐ Yes 2 X No Maryland Montgomery Potomac Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8919 Liberty Lane 20854 United States Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: white þ 3 Widowed 4 Divorced Completed event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) al Hygiene. Chemical and Elementary/Secondary (0-12) College (1-4or 5+) Owner Janitorial Supplies 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Deperment of Heature Importent; if Item 27 is marked any injury or other treumatic events. Nathan Goren Fannie Burka 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 10738 Normandie Farm Dr., Potomac, MD Barbara Needelman, Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 02/28706 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) King David Memorial Garden Falls Church, VA 21. Signature of Fune al Selvice 22. Name and Address of Facility Torchinsky Hebrew Funeral Home Pan Ed The disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a. Part Fa Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Dysphagia /Medical Due to (or as a consequence of): **Examiner** Dementia Sequentially list conditions, if any, leading to immediate that Inderlying Cause (Disease or injury that initiated events could not be a sequence of the co Due to (or as a consequence of): Examiner The law requires that the death certificate be executed Atherosclerotic Vascular Disease resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, the attending physician Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death
Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No signed by to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Peripheral Vascular Disease 2 No 3 Probably 4 □Unknown 1 Yes Completed peeu 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? certificate 1 ☐ Yes 2 ☐ No 1 Yes 2**X** No To the Hospitel or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other:  $_{4}$  Nursing Home  $_{5}$  Residence  $_{6}$  Y ther (Specify) Assisted 1 ☐ Yes 2 ☐ No Certification; To 3 DOA this I Director: After this ad in by the funeral d 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Living 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours e 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medicai (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 02/27/06 29b. Signature and title of certifier D 35579 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Susan J. Miller, M.D., 6844 Tulip Hill Terrace, Bethesda, MD 20816 32. Registrar's Signature Day, Year) State 28 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death FEBRUARY <sup>Day</sup> 26 **Physician** 2006 7:30 P M CLARA GEIER /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner MONTGOMERY BETHESDA SUBURBAN HOSPITAL If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
JULY 18, 1911 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 □ M 2 F Months 94 POLAND 579-40-6694 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State or 28a-f show or than "naturel", or Iteme 23a or 28a-f show the Medical Examinar must be notified at 1 ☐ Yes 2X No MONTGOMERY SILVER SPRING Directo 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code 14 REDGATE COURT 20905 USA death Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black White etc Pages 1 and 2 should be filled within 72 hours after nent of Health and Mental Hygiene. int: If item 27 is marked other than "naturel", or Ite 1 ☐ Yes 2 X No If Yes, Give 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: þ WHITE 3 ☐ Widowed 4 💆 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Cottege (1-4or 5+) Elementary/Secondary (0-12) SCHOOL TEACHER MONTGOMERY COUNTY 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be lith and Mental F 27 is marked of r traumatic ever UNKNOWN MORRIS SHAMON REBECCA 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) MARK R. GEIER, M.D. - SON 14 REDGATE COURT SILVER SPRING, MARYLAND 20905 permit. Pages 1 and Depertment of Health Important: if item 27 eny injury or ather troonce. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State OLNEY, MARYLAND 2-28-2006 JUDEAN MEM. GARDENS 4 □ Donation 5 □ Other (Specify) 11800 NEW HAMPSHIRE AVE. 21. Signature of Juneral Se 22. Name and Address of Facility SILVER SPRING, MD HINES-RINALDI FUNERAL HOME, INC. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury Due to (or as a consequence of): Examine use as the burial-transit The law requires that the death certificate be executed that initiated events cete has been signed by the attending physicien and page 2 should be detached for use as the burial-trai resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Month Year Day 4☐Pregnant at time of death 5 Other (specify) 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 4 Unknown 1 Yes 2 No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 2 No 1 ☐ Yes 2 ☐ No certificate 1□ Yes or Attending Physician: director, 25. Was case referred to medical 26. Place of Death | Check only one | Certification: To Be Hospital: 1 X Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA this ŏ 28c. Injury at Work? funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death After Division Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. 2 ☐ Accident investigation filled in by the fi 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 | Homicide Hospital within 24 hours of To the Funeral 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 9 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BETHESDA, MD 20851 8600 OLD GEORGETOWN RD MV 31. Date filed (Month, Day, Year) 32 Registrar's Signature State FEB 28 2006 Registrar

1. Decedent's Name (First, Middle, Last) **Physician** 1440 M 200 lichae Sarviw /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore
If Under 1 Year If Under 24 Hrs. NONE Maryland University 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Months Days Hours **X** M 2□ F Yrs. 578-60-7111 60 JAN. 6, 1946 WASH. D.C. Director Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location 28a-f show the Medical Examiner must be notified at X□Yes 2□No Director D.C. NONE WASHINGTON 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code or items 23s or U.S.A. 4034 BLAINE ST. N.E. 20019 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 XYes 2 No If Yes, Give VIETNAM Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: þ 3 Widowed 4 Divorced WHITE natural Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) other than Elementary/Secondary (0-12) College (1-4or 5+) 12 MECHANIC **PEPCO** permit. Pages 1 and 2 should be filed wi Department of Health and Mental Hygien Important: If Item 27 Is marked other th eny linjuy or other traumatic event, the once. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be WILLIAM **JEFFERSON** GARVIN DOROTHY MASTERS ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) MARY ANN KUZNIAR/FRIEND 4921 SEMINARY RD. #720, ALEXANDRIA, VA. 22311 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ▼ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) CEDAR HILL CEMETERY 3-2-2006 SUITLAND, MD. 21. Signature of Funeral Service Lipersee 22. Name and Address of Pacility
CHAMBERS FUNERAL HOME & CREMATORIUM, P.A. 5801 CLEVELAND AVE., RIVERDALE, MD. 20737 -M00091 23á. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** VICIO /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): ( The law requires that the death certificate be executed use as the burial-transit and Due to (or as a consequence the ettending physicien Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month Year cate hes been signed by the ette , page 2 should be detached for in the past 12 months? 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 ☐ Probably 4 Dunknown 1 ☐ Yes 2 ☐ No Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate hes autopsy performe 1 ☐ Yes 2 ☐ No 1 Yes 285 No or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 12 Ves 2 No Inpatient Certification; To 2 ER/Outpatient 3 DOA 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Natural 5 Pending 1 ☐ Yes 2 ☐ No death. 2 Accident investigation within 24 hours efter death To the Funerel Director: the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Hospitel 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Image: Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one the 29d. Date signed (Month, Day, Year) e and title of certifier 29c. License number 2 2006 d address of person who completed cause of death (Item 23a) (Type, Print) AR South Greene

Registrar

State

31. Date filed (Month, Day, Year)

FEB 28

2006

32 Registrar's Signature

		1 - For State Registrar	State of Mar	-	epartme Certifica			and Mo	, ,	ene g. Nø.	006	07743
*		1. Decedent's Name (First, Middle, Last)					•		Date of Death     Month	Day	Year	3. Time of Death
Physicia /Medic		James Mervin Grov	es						2	28	2006	5:33 A M
Examin		4a. Fecility Name (If not institution, give s	treet and number)		4b. Ci	ty, Town, or	r Location o	of Death		4c. Co	unty of Death	
		3 Dawn Isle				cean I					ceste	<u> </u>
Funeral		5. Social Security Number 6. Sex	M 2DE	(In yrs. last birtho	Month		If Under	24 Hrs. Min.	8. Date of Birth (Month, Day, 7 / 17 / 192	Year)	9. Birth	place (State or Foreign intry)
Director		220-14-48/1		82 Yrs	5.				//1//192	23		MD
pua 🗼		Usuel Residence of Decedent  10a, State 10b, County		10c. City, Town o	r Location						T	10d. Inside City Limits
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a Sa or		3 Dawn Isle				218	211				TICA	·
death me 2:	Funeral		12. Was Decedent Ev	ver in U.S.	13. Was De	cedent of H	ispanic Orig	gin? (Spe	cify Yes or No-		USA Race - Amer	
o in the interest of the inter		1 Never Married 2 Married	Armed Forces? 1 □XYes 2 □ No		If Yes, s	респу Сиба	in, Mexican	i, Puerto F	(ican, etc.)		Black, White	
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ING X IX I 3-UU30 be filed within 72 hours after death with the Maryland tal thygiene. d other than *naturel*, or tteme 23a or 28e-f ehow event, the Medical Examiner must be notified at	Completed	15. Decedent's Edu (Specify only highest grade	cation	16a. D	ecedent's U Give kind of	work done	during most	t of workin	g 1	6b. Kind	of Business/li	ndustry
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2 0 0 0		Joseph A. Groves	be, Print)								-	p Code)
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UNISION OF VITA  To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director,		29a. Certifier 1☐ Certifying Phys	sicien: To the best of	my knowledge i	death occur	ed at the time	ne date an	d place a	nd due to the ca	usa(s) an	d manner as	stated
24 h 24 h Fun etely	Medical		ner: On the basis of e	examination and/								
o the	Me	29b. Signature and title of certifier	>			29c. Licens	e number		29	d. Date si	igned (Month	, Day, Year)
F > F 0		& Mel	Lu			Da	462	57	7	2.	-28-	-06
		30. Name and address of person who co	mpleted cause of dea	ath (Item 23a) (Tr	/pe, Print)	2 .	-	0	neid			0 :
		10324 00			in	BLV	D.	150	zein	Mi	0 21	01/
Sta	te	31. Date filed (Month, Day, Year)	32. Registrar	's Signature	has	L'S						

			For State Registrar		State of M	Marylan		artmer rtificat				ental Hy	gien Reg N	MAG	07744
	Physici		1. Decedent's Name (First, Midd Joseph Gol		eider							2. Date of De Month 02/		ay Year	3. Time of Death 12:10 P M
	/Medio Examir		4a. Facility Name (If not institution Shady Grove Ad				-		Town, or		of Death		4	c. County of Deal	
	Funeral Director		5. Social Security Number 131–22–7995	6. Sex	M 2□F	Age (In yrs. 98	last birthday) Yrs.	If Unde Months	Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da 04/02/	190	9. Bin Co 7 Pol	hplace (State or Foreign buntry) and
	Maryland f ehow	tor	Usual Residence of Decedent	•	у	10c. City	y, Town or Lo	ocation		<del></del> -					10d. Inside City Limits 1 ☐ Yes 🌠 No
	death with the Maryland ms 23a or 28a-f ehow prount by notified at	al Director	10e. Street and Number 11710 Seven Lo	cks	Road				Code 854				10g. C	itizen of What Co	ountry?
020	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Dependment of Habith and Mandal Hygiens. Important: if item 27 is marked other than "natural; or items 23e or 28e-f ehow eny injury or other treumatic event, Ite Madical Examinar must be notified at once.	by Funeral	11. Marital Status 1 □ Never Married 2 ሺ Mar 3 □ Widowed 4 □ Divorce	rried	2. Was Decede Armed Force 1 ☐ Yes 2 ( If Yes, Give Year or Date	s? XNo		Was Dece If Yes, spe	cify Cuba	spanic Or n, Mexica Specify	n, Puerto I	cify Yes or No Rican, etc.)	) <b>-</b>	14. Race - Ame Black, Whit Specify: Wh	e, etc.
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е, маг	1 and 2 sho fealth and om 27 is m ther treum		19a. Informant's Name/Relation Ruth Goldschei  20a. Method of Disposition		(wife)	20h P	19b. Mailir 1171(	Sev	en L		Road		tom	or Town, State, 2 Lac, MD 2 Location - City or	20854
Saltimore	iit. Pages artment of P artant: If its njury or gi		1 Donation 5 Other (: 21. Signature of Funeral Service	Specify)		· c	lean Me	natory or	al G	ins C	2/17			ey, MD	Town, Glaid
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ă	death e atter id for u	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23	Sc. If yes, outcor 1 Live birth 4 Pregnant 9 Unknown	2 □ Feta at time of d	Ideath 3	⊒Ectopic p ⊒ Other (s <sub>i</sub>						23d. Date of de Month	ivery Day Year
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	ne Hospita n 24 hours ne Funerei detely fillec	edical C	29a. Certifier 1 Certifyi (Check only 2 Medica	ng Physi I Examin	ician: To the be er: On the basis and manner	of examina	wiedge, deat tion and/or in	h occurred vestigation	at the tim	e, date a pinion, de	nd place, a ath occurre	and due to the ed at the time,	cause( date a	s) and manner as nd place, and due	s stated. s to the cause(s)
)	3	Me	29b. Signature and title of certifit	ar W	1Cyn	1		29	C License	number	97	3		ate signed (Mont 2/24/2006	
			30. Name and address of person Martin McGrei	vy,	MD \	9901 1	Medica	1 Cen		Drive	e R	ockvil	le,	MD 20850	)
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			1- For State of Maryland / Department of State of Maryland / Certificate of	Doath
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	Examir			or Location of Death 4c. County of Death t City Howard
	Funeral Director		5. Social Security Number 6. Sex 1 XM 2 F 80 Frs. last birthday) If Under 1 Year Months Days	If Under 24 Hrs. 8. Date of Birth 9. Birthplace /State or Foreign
	h the Maryland or 28e-f show a cottlied at	Irector	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location  MD Howard 10e. Street and Number 10f. Zip Code	10d. Inside City Limits 1 □ Yes 2√2 No  10g. Citizen of What Country?
920	s within 72 hours after death with the Maryland liene. r then "natural", or Items 23a or 28e-f show the Medical Examinar must be cotified at	d by Funeral Director	3 Widowed 4 Divorced   If Yes, Give 1 Yes 2 No	Hispanic Origin? (Specify Yes or No- ban, Mexican, Puerto Rican, etc.)  Specify:  USA  14. Race - American Indian, Black, White, etc.  Specify: White
Maryland 21215-0036	within liene. r then "	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  16a. Decedent's Usual Occu (Give kind of work done life. DO NOT use retire)  College (1-4or 5+)  Sales	during most of working
aryland	should be filed ind Mental Hygi marked other umatic event, I	To Be (	17. Father's Name (First, Middle, Last) Howard Greene	18. Mother's Name (First, Middle, Maiden Sumame)  Ethel Chessman  t and Number or Rural Route Number, City or Town, State, Zip Code) 21044
Baltimore, Ma	permit. Pages 1 and 2 should Department of Health and Mer Importent: If item 27 is marke any injury or other treumatic QDGB.		Marian Greene/Wife  20a. Method of Disposition  15 Burial 2 Cremation 3 Removal from State  3 Other (Specify)  10101 Governo  20b. Place of Disposition (Name of cemetery, crematory or other plate of the plate of t	Dr Warfield Pkwy. #440 Columbia, MD  20c. Location - City or Town, State  20c. Spring 2006 Brid ton. ME
Bal	permit Depar Impor any in		21. Squato e of Funeral Service bicensee  22. Name and Address  23. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dyi	ess of Facility Harry H. Witzke's Family FH. Inc Columbia Pk. Ellicott City, MD 21043 ing, such as cardiac or respiratory arrest.  Approximate
8760,	death certificate be executed  Wedgical  Exam  death object of the form of the	ilcai Examiner	shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, flary, Leading to minured date cause. Enter Underlying Cause (Disease or injury that imitated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):	Interval Between Onset and Death
P.O. Box 6	death certific e attending p d for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	23d. Date of delivery  Month Day Year
	law requires that the de as been signed by the a 2 should be detached f	by	Part in Other significant conditions contributing to death but not resulting in the underlying cause give	ven in Part I. 23e. Did tobacco use contribute to the cause of death?  1   Yes 2   No 3   Probably 4   Unknown
Vital Records,	The ate his page	Completed		24a. Was an autopsy findings available prior to completion of cause of death?  1 Yes 2 No 1 Yes 2 No
of	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	ation: To Be	examiner?  1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA	26. Place of Death (Check only one)  her: 4 Nursing Home 5 Residence 6 Other (Specify)  ry at rk?  Yes 2 No
Division	To the Hospitel or Attending Phwithin 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)
	To the Hospitel within 24 hours a To the Funeral C completely filled i	ledical		opinion, death occurred at the time, date and place, and due to the cause(s)
)	To To	Σ	· (caplell/m) DS	B987 + TEJG BALTIMORG MD 21201
)Œ	Sta	te	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  KENNETH GEH, BOO ARWORY PU, SU,  31. Date filed (Month, Day, Year)  32. Registrar's Signature	TE 34 BALTIMORG MD 21201
	Registr	ar	FEB 2 8 2006 Mesers & Speeds	

			1 - For State Registrar	State of Marylan		artment of tificate o				giene Reg. No.	0	07746
	Physici		1. Decedent's Name (First, Middle, Last) Vallie G. Hidrobo						2. Date of Dea Month Februa		, 2 <sup>°</sup> 006	3. Time of Death 1:58 p M
	/Medio Examir		4a. Facility Name (If not institution, give s Montgomery Genera			4b. City, Town	n, or Location	n of Death		4c. Co	unty of Death Montg	omery
	Funeral Director		5/8-18-8988	7. Age (In yrs. 87	ast birthday) Yrs.	If Under 1 Ye Months Dar		er 24 Hrs. Min.	8. Date of Birtl (Month, Day March 2	7, Year) 7, 19	Cou	place (State or Foreign htry) rginia
	Maryland -f show	tor	Usual Residence of Decedent  10a. State 10b. County  D. C		y, Town or Lo							10d. Inside City Limits 1 ☐ Yes 2X☐ No
	with the	Director	10e. Street and Number 2824 31st Street,		io.rz.rg (	10f. Zip Cod				10g. Citizen USA	of What Cou	ntry?
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-f show many injury or other traumatic event, the Medical Evant and must be profiled at once.	by Funerai		12. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 [X] No If Yes, Give Year or Dates:	1		of Hispanic C uban, Mexic	an, Puerto i	cify Yes or No- Rican, etc.)	14.	Race - Amen Black, White, ecity: Whi	etc.
Maryland 21215-0036	d within 72 ho giene. er than "natur the Medical.	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12) 12		(Give life. I	dent's Usual Oc kind of work do DO NOT use rei ITSE ASS	ne during mo ired)		ng	16b. Kind o	of Business/In	,
land	uld be file Aental Hy, rked othe	To Be C	17. Father's Name (First, Middle, Last) Dillard Heiston						<i>(First, Middle,</i> e Moyer		name)	
, Mar	and 2 sho laith and ! 127 is ma er traums		19a. Informant's Name/Relationship (Ty) Segundo G. Hidrob			-			Route Numbe pt. 728	-		Code) , DC 20020
Baltimore,	nent of He int: If item		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	C Canal	emetery, crer	sition (Name of natory or other p n Cremato	place)	Februa			on-City or To	own, State Virginia
Balt	permit. Departnimports any inju		21. Signature of Funeral Service Licenses	lan	F1	Name and Ad ancis O Unive	dress d Fac ersity	Tins Blvd	Funeral , W, Si	Home lver	Inc Spring	MD 20901
	Physician /Medical Examiner		23. Part1. Enter the disease, or complishock, or heart failure. List only on Immediate Cause (Final disease or condition resulling in dealh)	cations that caused the death le cause on each line.  Due to (or as consequent	tion	0	tying, such a	1	r respiratory ar	rest,		Approximate Interval Between Onset and Death
8760,	icate be executed physicien and sthe burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence to (or as a consequence)								
.O. Box 6	The law requires that the death certific ate has been signed by the ettending plage? Should be detached for use as	by Physician/Med	IF FEMALE: 2: 23b. Was decedent pregnant in the past 12 months? 1  Yes  No 9 Unknown	3c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d	Ideath 3	Ectopic pregna Other (specify				23d.	Date of deliv	ery Day Year
rds, P	w requires that been signed b should be deta	ed by Pl	Part II. Other significant conditions con	tributing to death but not res	ulting in the u	nderlying cause	given in Par	t f.	23e. Did to			he cause of death? pably 4 Unknown
al Records,	: The law requ cate has been ; page 2 shoult	Completed							24a. Was autop perfor 1 Yes		4b. Were auto prior to co death? 1 \(\sum \) Yes	opsy findings available impletion of cause of 2 No
<u> </u>	Physician: r this certific ral director,	To Be	25. Was case referred to medical examiner?  1 Tyes 2 No	ospital: 1 KInpatient 2 🗆	ER/Outpatier	t 3 DOA	Other		ne 5 Resid		Other (Speci	(v)
Division of Vital	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page		27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. l	njury at Work?	2	28d. Describe h			,,
Divis	al or Atte s after de: al Directo ed in by th	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At ho building, etc. (Specifi	ome, farm, str v)	eet, factory, offi	СӨ	2	28f. Location (S City or Tow	Street and N m, State)	umber or Run	al Route Number,
	To the Hospital or Attending within 24 hours after death. To the Funeral Director; After completely filled in by the fune	Medical (	29a. Certifier (Check only one) Certifying Physical Examination (Check only one)	sician: To the best of my kno ner: On the basis of examina and manner stated.	wledge, death tion and/or in	n occurred at the vestigation, in m	a time, date a ny opinion, de	and place, a	and due to the dead at the time, d	cause(s) and date and pla	d manner as s ice, and due t	itated. o the cause(s)
)	~	ź	29b. Signature and title of certifier	han k	(D	29c. Lic		3169		$\frac{29d}{3}$	gned (Month,	Day, Year)
	5		30. Name and address of person who co	mpleted cause of death (Item	8101	Prince	Phil	io Dr	ive C	Slacu	Mo	20839
	Sta Registi		31. Date filed (Month, Day, Year) FEB 2 8 2	32. Registrar's Signa	ture	mente				J		

			For Stete Registrar	11000	Sta	ite of M	aryland	-	artmen rtificat			and M	lental Hy	Reg. No.	006	(	7747
	Dhamini		1. Decedent's Nam		,								2. Date of De Month	eath 1 <sup>Day</sup>	a o Xe	ar	3. Time of Death
	Physicia /Medic		Karen He										March				8:40 A M
	Examin	er	4a. Facility Name (		_					Town, or erst	Location of	of Death			County of C		o <b>n</b>
			11005 Cd		Avenue 6. Sex		je (In yrs. las	t hirthday)	If Under		If Under	24 Hrs.	8 Date of Bi				
	Funeral Director		5. Social Security N		1 □ M 2		je (III yrs. Ias	Yrs.	Months 2	Days 24	Hours	Min.	8. Date of Bi (Month, Di 12/08/	ay, Year)	3.	Cour	lace (State or Foreign try) MD
			220-73-3347 Usual Residence o	f Decedent						21			12/00/	2002			
	nyland how		10a. State	10b. County	acton			Town or Lo ersto								1	0d. Inside City Limits 1 ☐ Yes 2 No
	Ba-fs	c c	MD	Washir	igcom		nage	ELSCO									
	within 72 hours after death with the Maryland ene. then "natural", or items 238 or 288-f show the Madical Ext. cliner: ust be inclifted at	by Funeral Director	10e. Street and Nu 11005 Co		Avenue					.740				U			
	r dea	nei	11. Marital Status		An	as Decedent med Forces?	,	13.	Was Deced If Yes, spec	dent of Hi cify Cuba	spanic Ori n, Mexicar	gin? (Spe 1, Puerto	ecify Yes or N Rican, etc.)	0-	14. Race - A Black, V		
36	s afte	γF	1 XNever Man 3 ☐ Widowed	ried 2 Marrie	lf Y	∃Yes 2. <b>2</b> X ∕es, Give par or Dates:	No		1X Yes	2□ No	Specify:	Elsa	vador		Specify:		
21215-0036	hour tural	ed b	3 - Widowed	15. Decedent		ar or Dates:		16a. Dece	dent's Usua	al Occupa	ation			16b. Ki	nd of Busin	ess/Ind	dustry
5	in 72 n "na Nadio	piet		cify only highest	grade com			(Give	kind of wo DO NOT u	rk done d se retired	turing mos )	t of work	ing				,
212	t with piene. r tha	Completed	Elementary/Seco	ondary (0-12)		llege (1-4or	5+)	]	None						ne		
Maryland 2	parmit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or othar traumatic event, the Madical Experiment contact traumatic event, the Madical Experiment contact.	To Be C	17. Father's Name Unl	(First, Middle, L	ast)						18. Mothe Sai	or's Name Otos	Pedrir	e, Maiden 1a Es	<sub>Sumame)</sub> trada		
ary	shor and M	5	19a. Informant's N	lame/Relationsh	ip (Type, Pr	int)		19b. Maili	ng Address	(Street a	and Numbe	er or Rura	al Route Numb	ber, City o	r Town, Sta	te, Zip	Code)
	and 2 salth a n 27 is		Santos	Pedrina E	strada	/ Mothe							MD 2174				
ore	of He of He or oth		20a. Method of Dis	position  Cremation	3 ⊟Remova	al from State	20b. Plac	ce of Dispo netery, crea	nsition (Nar matory or c	me of other plac	θ)		Date	20c. Lo	cation - Cit	y or To	wn, State
Ë	Pages ment of ant: If it		<sup>¹</sup> 4 □ Donation	5 ☐ Other (Sp	ecify)			sturg	Cremat	oriun	1   N	<b>arch</b>	2,2006	Suith	shun,	MD.	1 **
Baltimore,	permit. Departr Imports any inje	8 8	21. Signature of F	Sy->	2	6	2	3	305 N	. Pot	omac	Str	eet, Ha	agers			eral Home 21740
	Fnysician /Medical Examiner	8 5	Immediate Cause disease or conditi resulting in death)	art failure. List of (Final on	a.	Carol	d the death. ine. O C S a conseque	pura		fau fau	g, such as leve	cardiac	or respiratory a	arrest,			Approximate Interval Between Onset and Death
760,	ate be executed hysician and the burial-transit	ical Examiner	Sequentially list of any, leading to it cause. Enter Und Cause (Disease of that initiated event resulting in death)	5	c	Hyd	a conseque	enci	epha	ly	ь					J	inceprety
.O. Box 68	that the death certificate led by the attending phy detached for use as the	by Physiclan/Medic	IF FEMALE: 23b. Was deceded in the past 12 1 □ Yes 2, 9 □ Unknow	2 months?	1[ 4[	Live birth	e of pregnand 2	eath 3	A ⊒Ectopic p ⊒ Other (sp						23d. Date o Month	f delive	ory N/A Day Year
rds, P	Se bog		Part II. Other sign.	ificant conditio	ns contributi	ing to death I	but not result	ing in the u	ınderlying o	cause give	en in Part I		11.				ne cause of death? ably 4 □Unknown
Division of Vital Records,	The law requir ate has been si page 2 should i	ompleted				· · · · ·							24a. Wa auto peri 1 ☐ Yes	s an opsy formed? 2 D No	prio dea	r to co th?	psy findings available impletion of cause of
ita	ician: Th certificate ector, pag	BeC	25. Was case reference	erred to medical								of Deat	h (Check only	one)			10754
>	Physician: this certific ral director,	Jo.	1 ☐ Yes 2	1/6	Hospita	1 🗀 Inpati	-	R/Outpatie			4 140		me 5 Res		6. Other (	Specif	"TO ATO
0	ng Ife	ü	27. Manne of Dea	ith 5 ☐ Pending		a. Date of Inj (Month, Da	ury ay Year) 2	8b. Time o		28c. Injun Worl	k?	IA	28d. Describe	how inju	y occurred		
Sio	Attanding r death. actor: After	cati	2 Accident	investig 6 ☐ Could n	ation	N/	A	NA	М		Yes 2□	No	NIA	/Chront or	at Atrombour	or Com	I Route Number,
×	or Atl fter d Siract in by	Certification;	4 Homicide	dotomi	ned 286	e. Place of tr building, e	ijury - At hom tc. <i>(Specify)</i>	ie, farm, st	reet, tactor	y, office			City or To	own, State	)	or mura	i noute Number,
]	To the Hospital or Attandi within 24 hours after death. To tha Funaral Diractor: A completely filled in by the to	ledicai Ce	29a. Certifier (Check only one)	1 Certifying	Examiner: C	: To the besi	of examination	ledge, dear on and/or in	th occurred evestigation	at the tin	ne, date ar pinion, dea	nd place, ath occur	and due to the red at the time	e cause(s e, date and	and manne place, and	er as s due to	tated. o the cause(s)
	thin 2 tha tha mplel	Med	29b. Signature an	d title of certifier	a	ing manner s	ialou.		29	c. Licens	e number			29d. Da	e signed (A	Aonth,	Day, Year)
)	2 2 2 3		Mo	In ~	dur	1 00	11-4-1			Λ	587	10C=			3/02	21.	2007
		1	30. Name and add	fresh of person s	who complet	ed cause of	death (Item :	Clan 23a) (Typa	Print)	U	10 1	06			3102	=/	2016
S	4-1		and det	DA	. MA	FRIA	DAN	153	19 E.	Ant	ietam	St.	, Hage	rsto	vn, MI	)	21740
	Sta Regist		31. Date filed (Mo	nth, Day, Year)	2 2006	32. Regist	trar's Signatu		Sperk								

			For State Registrar	State of Maryland			t of Hea		Mental Hy	giene	IIII	07	1748
			Decedent's Name (First, Middle, Last)						2. Date of D	eath Da	y Yea		me of Death
	Physicia /Medic		John	С.		H	oma		Febru	ary:	25 200	6 10	-05 A M
	Examin	er	4a. Facility Name (If not institution, give st	44 1 . 7 /	100 100	4b. City,	1 .	cation of Dea	•		County of De		-1
			5. Social Security Number 6. Sex	7. Age (In yrs. I	er highday)	If Under		OUTNI f Under 24 Hr			inne A		
	Funeral Director			M 2□F 71	Yrs.	Months		Hours Mir		ay, Year)		ennsy1	tate or Foreign
			Usual Residence of Decedent						Hug. Z		777 16		
	uryian thow		10a. State 10b. County	10c. City	, Town or Loc	cation							de City Limits
	Ba-1 a	Director	MD Anne Arun	del Gle	n Burn								Yes 2 No
	with the	급	10e. Street and Number			10f. Zip				10g. Cr	tizen of What	Country?	
	eath	Funeral	764 Hammarlee Road	• Apt • K  2. Was Decedent Ever in U.S	S. 13. V		1061	anic Origin?	Specify Yes or N	0-	USA 14. Race - Ar	nerican India	an.
0	ifter d	표	1 Never Married 2 Married	Armed Forces? 1 201 Yes 2 ∐ No	If	Yes, spec	cify Cuban, I	Mexican, Pue	erto Rican, etc.)		Black, Wi		
3-003c	ral', c	d by	3 XWidowed 4 ☐ Divorced	ff Yes, Give Year or Dates:		Yes	2LALNO S	Specify:			Specify:	White	
ה	72 h	Completed	15. Decedent's Educa (Specify only highest grade		16a. Deced (Give	kind of wo	rk done duri	on ing most of w	orking	16b. K	(ind of Busines	s/Industry	
7	within ane. than	d L	Elementary/Secondary (0-12)	College (1-4or 5+)	Syste	m An:					NSA		
70	filed Hygid Sther	ပိ	17. Father's Name (First, Middle, Last)		Бувес	III TIII		3. Mother's N	ame (First, Middl				
land	lid be lental ked c	To B	Michael Homa					Anna (	Chopack				
Mary	should have		19a. Informant's Name/Relationship (Typ	e, Print)	19b. Mailin	g Address	(Street and	Number or I	Rural Route Num	ber, City	or Town, State	, Zip Code)	
e, Œ	and 2 ealth n 27 I		Ed Homa (Brother)					eet, Ne	ew Haven	<del></del>			
9	ges 1 of Ho If Iter		20a. Method of Disposition 1 ☐ Buriaf 2 ☒ Cremation 3 ☐ Re	0.0	ace of Dispos metery, crem	sition (Nar natory or c	ne of ther place)		Date	20c. L	ocation - City	or Town, Sta	ite
aitimor	t. Pa tmen tant:		4 □ Donation 5 □ Other (Specify)		ro Cre		J	1		Ba1	timore,	MD	
g D	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If term 27 is marked other than "natural", or iteme 23s or 28s-f show important: If term 27 is marked other than "natural", or iteme 23s or 28s-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Licenses			Hard	d Address d esty I	Funera	1 Home,	P.A.			
			23a. Part1. Enter the disease, or complic	ations that caused the death	. Do not ente	12 R: er the mod	idgely le of dying, s	Avent such as cardi	ae, Anna ac or respiratory	poli: arrest,	s, MD /	Appro	ximate
	Physician		fmmediate Cause (Final	PAN CRE				NCE				Onset	al Between and Death WEE/CS
	/Medical		disease or condition resulting in death)	Due to (or as a consequ								6	WCE147
	Examiner		Sequentially list conditions b										
	ם יו	Iner	Sequentiafly list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consequ	ence of):	_		-					
	and I-trans	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequ	ience of):			-					
8/60,	death certificate be executed e attending physicien and id for use as the burial-transit	alE	L.		,.								
200	ficate g phys	edicai	d.										
žog	h cert	N/W	23b. was decedent pregnant	c. ff yes, outcome of pregnal		Ectopic pi	20000001				23d. Date of c	lelivery	
	s deat	stcta	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant at time of de 9☐Unknown		Other (sp					Month	Day	Year
J.	es thet the death certific igned by the attending p be detached for use as	Physician/Me	9 ☐Unknown  Part II. Other significant conditions cont		thing in the	adaab da a a		in Dard I	220 Did	tobacco	use contribute	to the same	o of doath?
Š	requires thet een signed b hould be deta	by	Part II. Other significant conditions cont	induling to death but not resu	nung in ine ur	iderlying c	ause given	ın ran I.		Yes 2			4 🖾 tinknown
Hecord		Completed							24a. Wa				
ě	a 8 C	m Id							aut	opsy formed?	prior t death	o completion	dings available n of cause of
VItal	in: The lificete he or, page	ပိ	25. Was case referred to medicaf	<u> </u>			2	6 Place of D	1 ☐ Yes eath (Check only	2 No	0 1□Y	es 2 No	,
	Physician: this certific ral director,	0 8	examiner?	ospital:	ER/Outpatien	t 3 🗆 D0	Othor		Home 5 Re	- 1	6 □Other (Si	pecify)	
פֿר	ttending Physician: leath. tor: After this certific the funeral director,	n: T	27. Manner of Death 1 Matural 5 Pending	28a. Date of fnjury (Month, Day Year)	28b. Time of		8c. fnjury at Work?		28d. Describe			,,	
sion	endin sath. or: Af he fur	atlc	2 Accident investigation			М		s 2 No					
Ž	or Att	Certification;	3 ☐ Suicide 6 ☐ Could not be determined	28e. Ptace of Injury - At ho building, etc. (Specify	me, farm, stre	eet, factor	y, office		28f. Location City or To	(Street al	nd Number or 'e)	Rural Route	Number,
	To the Hospitel or Attending within 24 hours effer death.  To the Funeral Director: After completely filled in by the fune.		29a. Certifier 1 Certifying Physi	cian: To the best of my know	wledge, death	occurred	at the time,	date and pla	ce, and due to the	e cause(s	s) and manner	as stated.	
	the Ho in 24 the Fu	Medical	one)	er: On the basis of examinat and manner stated.	ion and/or inv				curred at the time				
	To the within To the compl	2	29b. Signature and title of certifier	or on	4.,	290	c. License n	umber	762	29d. Da	ate signed (Mo	nth, Day, Ye	iar)
			M. SHIRAZI, M.D.			tine C	TON	MEI	OICAL C	EN	TER.	MD :	21061,
200	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Signat	ture	1	•						

			State State Registrar  State State Registrar  Certificate	of Dooth	16 07749	
			Registrar  1. Decedent's Name (First, Middle, Last)	2. Date of Death	3. Time of Death	
п	Physicia		Betty Sue Harding	February 23, 2	2006 12:30A M	
	/Medic Examin			wn, or Location of Death 4c. Count	ty of Death	
			Wilson Health Care Center Gaithe		tgomery	
	Funeral		1 □ M 287 F   Months   D	Pays   Hours   Min.   (Month, Day, Year)	Birthplace (State or Foreign Country)	
	Director		214-30-2344 73 73 Vrs. Usual Residence of Decedent	April 21, 193	2 Washington D.C	
	72 hours after death with the Maryland natural', or Items 23a or 28e-f show lisal Evanti et must be nudified at		10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits	
	Be-f s	Director	Maryland Montgomery Germantown		1 ☐ Yes 2X No	
	with th	Dire	10e. Street and Number 10f. Zip Co	77 0 1	What Country?	
	ns 23	Funeral	22601 Wildcat Road         208           11. Marital Status         12. Was Decedent Ever in U.S.         13. Was Decedent		ce - American Indian,	
က	or Item		1 🟋 Never Married 2 ☐ Married 1 ☐ Yes 2 📆 No	Cuban, Mexican, Puerto Rican, etc.) Bla	ack, White, etc.	
03	ral', c	d by	If Yes, Give A 1 ☐ Yes 2 ☑ Year or Dates:	No Specify: Specific	White	
21215-0036	"natu	Completed	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual O (Give kind of work of	Occupation 16b. Kind of Education 16b.	Business/Industry	
12	within ene. then "	duic	Elementary/Secondary (0-12) College (1-4or 5+) 6+ Librarian		omery County	
9	be filed within 72 hours after death with the Marylan ital Hygiene. Ind other then "natural", or Items 23a or 28e-f show event, The Medical Exprint of must be recitived at	a)	17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surnal	me)	
/lar	should be nd Mental marked c matic eve	To B	George Harding	Catherine Sagrario		
Maryland	2 should and Men Is marke aumatic		19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (St	treet and Number or Rural Route Number, City or Town		
	is 1 and 2 should of Health and Men item 27 is marke other traumatic			lcat Road, Germantown, Man	ryland 20876 - City or Town, State	
וסר	nt of h		1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State	2/1/06		
Baltimore,	permit. Pages 'Department of Himportent: If ite any Injury or of 2006.		4 □ Docation 5 □ Other (Specify) Parklawn Memori 21. Signature of Funeral Service/Nicensee		lle, Maryland	
Ba	Depa Impo any l			Address of Facility in-Williams P.A., Funeral idge Road, Damascus, Mary		
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of shock, or heart failure. List only one cause on each line.	f dying, such as cardiac or respiratory arrest,	Approximate Interval Between	
	Physician			to there	Onset and Death	
	/Medical Examiner		resulting in death)  Due to (or as a consequence of):	to Throve		
H	-	<u>-</u>	Sequentially list conditions, if any, leading to immediate b.	ace (		
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury			
Ó	be executed ician and burial-transit		resulting in death) Last  Due to (or as a consequence of):			
8760,	ate be executed hysician and the burial-transit	licai	d			
9	death certificate e attending phys id for use as the	Physician/Med	IF FEMALE: 23c. If yes, outcome of pregnancy	001.0	-44 del'	
Вох	eath certif attending for use as	cian	in the past 12 months?	nancy	ate of delivery onth Day Year	
P.O.	the d by the ached	hysi	1 Yes 2 No 4 Pregnant at time of death 5 Other (specing) Unknown	,,		
	law requires that the de as been signed by the a 2 should be detached f		Part II Other significant conditions contributing to death but not resulting in the underlying cause Fark was Succeeded by Part	e given in Part I 23e. Did tobacco use con	ntribute to the cause of death?	
ord	w require been si should b	ted		1 ☐ Yes 2 ☑ No	3 Probably 4 Unknown	
Records,	e law r has be je 2 sh	Completed by	Anemia I chemie disease.	autopsy	Were autopsy findings available prior to completion of cause of	
<u>E</u>	Th ate pag		degeneralis.	performed? 1 ☐ Yes 2 D No	death? 1 ☐ Yes 2 ☐ No	
Vital	sicien; certific irector,	o Be	25. Was #ase referred to medical examiner?  1  Yes 2 No	26. Place of Death (Check only one)  Other: 4 Nursing Home 5 Residence 6 Oth	har (Charles)	
of	Attending Physicien: r death. sctor: After this certifici	$\vdash$	27. Manger of Death 28a. Date of Injury 28b. Time of 28c.	Injury at Work? 28d. Describe how injury occur		
ion	tending l death. tor: After the funer	atio	2 Accident investigation M	1 Yes 2 No		
Division	or Attendenter de Olrecto	Certification;	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, of building, etc. (Specify)	ffice 28f. Location (Street and Numi City or Town, State)	ber or Rural Route Number,	
	• Hospitel or Attens 24 hours efter death • Funerel Director: etely filled in by the		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at t	the time, date and place, and due to the course(s) and m	annor as stated	
	To the Hospitel or Al within 24 hours effer of To the Funerel Direc completely filled in by	edical	(Check only one)  2 Medical Examiner: On the basis of examination and/or investigation, in and manner stated.	my opinion, death occurred at the time, date and place,	, and due to the cause(s)	
	To the within 2 To the complet	Me		icense number 29d. Date signe	ed (Month, Day, Year)	
)			Makettrochharles	10411s telene	aug 23,2006	
	3		1) I Robert BIRSCHBALLE MD 6 ACTITERS BURG, Was 20877			
	Sta Registr		31. Date filed (Month, Day, Year) FEB 2 7 2006  32. Pagistrar's Signature			

			State of Maryland / Department of Health and Mental Hygiene    For Registrar   Certificate of Death   Reg. 70. 0 6 0 7 7 5 0
			1. Decedent's Name (First, Middle, Last)  2. Date of Death Month Day Year  Annual Property of Death
	Physicia /Medic		Peggy Lee Hill February 23, 2006 3:36A M
	Examin		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death  4c. County of Death
			11809 Weller Road Monrovia Frederick
П	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month), Day, Year) Gountry  1
	Director		212-50-9979 57 Yrs. Jan 20, 1949 Maryland Usual Residence of Decedent
	/land		10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits
	Many I-f sh	to	Maryland Frederick Monrovia
	I within 72 hours after death with the Maryland liene. Than "natural", or Items 23a or 28a-f show the Medical Exam for must be codified at	Funeral Directo	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?
		aic	11809 Weller Road 21770 U.S.A.
	tems	nuel	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  13. Was Decedent of Hispanic Origin? (Specify Yes or No-Black, White, etc.)  14. Race - American Indian, Black, White, etc.
36	s afte	by Fi	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No 3 ☐ Widowed 4 ☐ Divorced Year or Dates:  1 ☐ Yes 2 ☐ No Specify: Specify: White
21215-0036	hour	ed t	15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry
5		Completed	(Specify only highest grade completed) (Give kind of work done during most or working life. Do NOT use retired) Medical Management &
212	d within jiene. r than "	E O	Elementary/Secondary (0-12) 12  College (1-4or 5+) Administrative Assistant Billing Services
	be filed within ital Hygiene. Ind other than event, the we	a)	17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Maiden Sumame)
lar	0 5 6 0	To B	Glenn Grimes Eva Flook
Maryland	s 1 and 2 should f Health and Mer item 27 ia marke other traumatic		19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
	and and and and and and and and and and		Edward H. Hill, Sr Husband 11809 Weller Road, Monrovia, Maryland 21770
ore	0 0		20a. Method of Disposition  1 ▼ Burial 2 □ Cremation 3 □ Removal from State
Ë	Pages ment of I tant: If its		'4 Donatto 5 Other (Specify) Providence Methodist Cem. 2/27/06 Monrovia, Maryland
Baltimore,	permit. Pag Department Important: I any Injury o		21. Signature of Fulleral Serves Licencee Molesworth—Williams P.A., Funeral Home
	403 a d		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Bathagen
Н			shock, or heart failure. List only one cause on each line.
	Pnysician / /Medical		Immediate Cause (Final disease or condition resulting in death)  a. Respiratory Failure West's
	Examiner		disease or conditions.  Sequentially list conditions.  display learning to immediate but to for as a consequence vij:  Due to for as a consequence vij:  Due to for as a consequence vij:
		-e	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):
	uted 1 ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.
Ć,	be executed sician and burial-transit	Exa	that initiated events c
8760	ate be nysicia he bur	icai	d
9		Jedi	IE ECHAIC.
Box	eath certific	an/h	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 23d. Date of delivery Month Day Year
	b dea	sici	1   Yes 2   No   Hokonin
P.0	at the de	Physician/Med	9 Unknown  Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of death?
	res that signed b	þ	The significant containing to death out not resulting in the directlying cause given in at it.  1  Yes 2 No 3 Probably 4 Unknown
Records,	w requir been si should	Completed	24a. Was an 24b. Were autopsy findings available
3ec	elaw hast je 2 s	ig m	autopsy prior to completion of cause of performed? death?
alF	ding Physician: h. After this certifica funeral director, p		1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 ☑ No
Vital		o Be	25. Was case referred to medical examiner?  1   Yes   2   Mo   Hospital: 1   Inpatient   2   EP/Outpatient   3   DOA   Other: 4   Nursing Home   5   Residence   6   Other (Specify)
of			27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred
		tior	1 ☐ Watural 5 ☐ Pending (Month, Day Year) Injury Work? 2 ☐ Accident investigation M 1 ☐ Yes 2 ☐ No
Division	or Attendi after death. Director: A in by the fu	ifica	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number,
Ö	al or A s after il Dire ed in by	Certification;	4 ☐ Homicide building, etc. (Specify) City or Town, State)
	bour hour uners		29a. Certifier (Check only (Check only (Deck only 2) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
	To the Hospital or Attenwithin 24 hours after deat To the Funeral Director:	ledical	one) and manner stated.
	With To	Σ	29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)
	1		D 9 / 8 6 6 February 24, 2006
	5		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
	* *		Kanan H. Hudhud, M.D. 46B Thomas Johnson Drive, Frederick, Maryland 21702
	Sta Regist	atė rar	31. Date filed (Month, Day, Year)  FEB 2 7 2006  32. Refistrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician**  $\mathbf{A}^{\mathsf{M}}$ February 2006 Mary Genevieve Hatfield 8:55 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Catonsville

If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)

Feb. 27, 1912 Pennsylvania Frederick Villa Nursing Center 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 F 161-18-1769 93 Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State show r than "natural", or Itams 23a or 28a-f shov the Maulcal Examinar must be notified at 1 Yes 2 No Director Ellicott City Howard 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 2538 McKenzie Road 21042 USA death Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 No 1942-14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status a filed within 72 hours after de il Hygiene. Othar than "natural", or Itam 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0036 1 ☐ Yes 2 X No White If Yes, Give Year or Dates: 1945 þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12 College (1-4or 5+) Administrative Assistant Higher Education othar permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked othing any injury or other traumatic event. 18. Mother's Name (First, Middle, Maiden Sumame) 17 Father's Name (First Middle Last) Be Edward Ferry Alice McDale 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Alice Hegner/Daughter 6011 Jacobs Ladder Columbia, MD 21045 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 2/28/2006 Woodlawn, MD Woodlawn Cemetery \* 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Harry H. Witzke's Family FH, Inc. 21. Signature of Funeral Service Licensee 4112 Old Columbia Pk. Ellicott City, ND 21043 23a. Part f. Enter the disease, ir complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Failure to Thrive /Medical Due to (or as a consequence of) Examiner Dementia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine death certificate be executed inding physician and use as the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 | Fetal death 3 DEctopic pregnancy łō in the past 12 months? Month Dav Year 4 Pregnant at time of death 5 Other (specify) signed by the a 1 ☐ Yes 2 🖼 No 9 Dilinknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 CVA 1 Yes 2 No 3 Probably 4 Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? Dysphagia 24a. Was an has eged certificate 1 Yes 2□ No 1 Yes 2 No or Attending Physician: rector. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 2 ER/Outpatient 3□ DOA funeral dir this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation 2 Accident after death | Diractor: 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital 29a. Certifier Medical 1 🔯 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 24 within . 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifie D50303 2/27/2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 405 Frederick Road Suite 162 Catonsville, MD 21228 Rodolfo Fernandez, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 2006

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) \_2006 MARCH 6, Year **Physician** 6:56P M HENERY MAUDE /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner HAGERSTOWN WASHINGTON AVALON MANOR If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign
Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 6. Sex **Funeral** Days Hours 1 ☐ M 2 🗓 F 99 4/9/1906 OHIO Director 271-05-5443 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or Itams 23a or 28e-1 show any injury or other traumatic event, Ita Marical Examinary. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County HEDGESVILLE 1 Yes No W۷ BERKELEY Director 10f Zin Code 10g. Citizen of What Country? 10e. Street and Number 25427 USA 176 TUPELO DRIVE Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 □ Yes 2 💢 💥 o If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 💢 Yeo Specify: þ WHITE 3 □ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) DRUG STORE **CLERK** 9 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be DORA ELIOTT GEORGE CARR 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 176 TUPELO DRIVE, HEDGESVILLE, WV 25427 KARLA COOK/GRANDDAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State MARCH Date 1 Burial 2 remation 3 Removal from State SMITHSBURG, MD SMITHSBURG CREMATORY 7, 2006 ' 4 ☐ Donation 5 ☐ Other (Specify) 2. Name and Address of Facility BROWN FUNERAL HOME, P.O. BOX 821, 327 W. KING ST., WARTINSBURG, WV 25402 21. Signature of Funeral Service Licensee Charles ne lown 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Dementia **Physician** Mon / The /Medical Due to (or as a consequence of): Years. Examiner canur Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner or Attending Physicien: The law requires that the death certificate be executed the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ ☐ Known Hyputensian Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 1 Yes 2 ₩No completely filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 🗌 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After 5 Pending investigation 1 Matural 1 ☐ Yes 2 ☐ No М death. 2 Accident after death 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Thomicide To the Hospitel within 24 hours at To the Funerel D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical 29b. Signature and title of confiner 29d. Date signed (Month, Day, Year) 29c. License number 0001223 7/06 1 30. Name and address of person who comple ted cause of death (Item 23a) (Type, Print) DI. BOLARUM HagwibUn, MD 340-M. W. Sweet 31. Date filed (Month, Day, Year) 32. Régistrar's Signature State MAR 1 4 2006 Registrar

			_ FOI			21116 11753
	Dhamini		1. Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year
	_		JOHN WILLIAM HOLTON HARRIS		FEBRUARY	21, 2006   4:15 P <sup>M</sup>
	Examin	er	4a. Facility Name (If not institution, give street and number)			
			516 DOMINION ROAD		8 Date of Birth	*
м			1 <b>X</b> IM 2□F	Months Days Hours Min.	(Month, Day, Ye	ear) Country)
τ		1   Standard   Certificate of Death   County o				
os lyc	how	_	1. Separate   Control   Co			10d. Inside City Limits
N o	Sa-1 e	cto		CARROLL HARRIS   Control of Death   Control of De		
this th	a or 2		1. December   Procession   Pr		,	
, die	ns 23	eral	Decembers Name (Freet, Modelle, Last)  JOHN VILLTAM HOLTON HARRIS  Leadiny Name (Freet, Modelle, Last)  JOHN VILLTAM HOLTON HARRIS  Leadiny Name (Freet, Modelle, Last)  JOHN VILLTAM HOLTON HARRIS  Leadiny Name (Freet, Modelle, Last)  JOHN VILLTAM HOLTON HARRIS  Leadiny Name (Freet, Modelle, Last)  JOHN VILLTAM HOLTON HARRIS  Leadiny Name (Freet, Modelle, Last)  JOHN VILLTAM HOLTON HOAD  CHESTER  4b. Cep., Town, or Location of Death  Chester Research  CHESTER  QUEEN ANNE'S  Social Security Number  Leading Name (Freet, Modelle, Last)  JOHN VILLTAM HOLTON HOAD  CHESTER  100. Cept. Town or Location of Death  CHESTER  101. Control Treet Visual Hilliogray (J. Res.  Leading Name (J. Res. 1992)  JOHN VILLTAM HOLTON HOAD  Leading Name (J. Res. 1992)  JOHN VILLTAM Holton Hoad (J. Res. 1992)  JOHN VILLTAM HOLTON HOAD  Leading Name (J. Res. 1992)  JOHN JOHN HOLTON HOAD  Leading Name (J. Res. 1992)  JO			
Maryland 21215-0036	al', or item	Ď	1 □ Never Married 2 M Married Armed Forces?  1 □ Never Married 2 M Married   1 □ Never Married   1 □ Neve	If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	Black, White, etc.
2-0-2	natur	eted	Certificate of Death   Certificate of Death		b. Kind of Business/Industry	
7	Mer.	Continued of Death   Continued Print, Michael Land   Continued of Death   Continued of Deat				
2 2 3	her th	1. Doubsert's Names (Frist, Middle, Lake)  J. Doubs of Death  J. Doubsert's Names (Frist, Middle, Lake)  J. Doubs of Death  J. Doubsert's Names (Frist, Middle, Lake)  J. Doubsert's Names (Frist, Middle, Middle, Middle, Names (Frist, Middle, Middle, Middle, Names (Frist, Middle, Middle, Middle, Middle, Names (Frist, Middle, Middle, Middle, Middle, Middle, Names (Frist, Middle,				
anc	ed of	Be c				
aryla	mark mark	ř				
	alth ar 27 le 27 le r treu		KAREN OERTEL/DAUGHTER 2308	BLOOMINGDALE RD.,	CENTREVI	LLE, MD 21617
o -	item item		20a. Method of Disposition 20b. Place of Disposition	osition (Name of		
mor	nent c	1- Register Street (First, Moths, Lett)    Determine Street (First, Moths, Lett)   Det		STEVENSVILLE, MD		
Balt	Departm Importer any inju		F.	ELLOWS, HELFENBEIN	& NEWNAM CHESTER,	FUNERAL HOME, P.A.
			1. Deceder's Name (Pist, Middle, Last)   2. Due of Death   2. Due of Death   3. Deceder's Education   3. Dece		Interval Between	
P	hysician		Certificate of Death  Conserver Name (First, Aldroth, Last)  Delhi WILLIAM HOLTON HARRIS  Scality Name (Frost, Aldroth, Last)  Delhi WILLIAM HOLTON HARRIS  Scality Name (Frost, Aldroth, Last)  Delhi WILLIAM HOLTON HARRIS  Scality Name (Frost, Aldroth, Last)  Delhi WILLIAM HOLTON HARRIS  Scality Name (Frost, Aldroth, Last)  Delhi WILLIAM HOLTON HARRIS  Scality Name (Frost, Aldroth, Last)  Delhi WILLIAM HOLTON HARRIS  CLESTER  COLESTER  Scality Name (Frost, Aldroth, Last)  Delhi William Scality Name (Frost, Marth, Walth, Marth, Marth, Walth, Marth, Walth, Marth, Walth, Marth, Walth, Marth, Walth, Wa			Onset and Death
	/Medical	The Segment of Control				
	.xamaici	<u>.</u>	HIN WILLIAM HOLTON HARRIS  With WILLIAM HOLTON HARRIS  About Seculty Name (If not institution, yew street and number)  About Seculty Name (If not institution, yew street and number)  About Seculty Name (If not institution, yew street and number)  About Seculty Name (If not institution, yew street and number)  About Seculty Name (If not institution, yew street and number)  About Seculty Name (If not institution, yew street and number)  About Seculty Name (If not institution, yew street and number)  About Seculty Name (If not institution, yew street and number)  About Seculty Name (If not institution, yew street and number)  About Seculty Name (If not institution, yew street and number)  About Seculty Name (If not institution, yew street and number)  About Seculty Name (If not institution, yew street and number)  About Seculty Name (If not institution, yew street and number)  About Seculty Name (If not institution, yew street and number)  About Seculty Name (If not institution, yew street and number)  About Seculty Name (If not institution, yew street and number)  About Seculty Name (If not institution, yew street and number)  About Seculty Name (If not institution, yew street and number)  About Name (If not institution, yew street and number)  About Name (If not institution, yew street and number)  About Name (If not institution number)  About Name (If not institution number)  About Name (If not institution number)  About Name (If not institution number)  About Name (If not institution number)  About Name (If not institution number)  About Name (If not institution number)  About Name (If not institution number)  About Name (If not institution number)  About Name (If not institution number)  About Name (If not institution number)  About Name (If not institution number)  About Name (If not institution number)  About Name (If not institution number)  About Name (If not institution number)  About Name (If not institution number)  About Name (If not institution number)  About Name (If not institution number)  About N			
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89	ig phy as th	led	The state of the s			
Records, P.O. Box 6	the attendir	ysiclan/N	23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No  23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 4 Pregnant at time of death 5			
S, D	gned by	by Ph		111	23e. Did tobac	cco use contribute to the cause of death?
ord	en si	ted	CORONIC UBSINIUCINE		1 Yes	2 No 3 Probably 4 Unknown
I Records,		Comple		DISEVISE	autopsy performed	
Vital	entific actor,		examiner?		th (Check only one)	
	this c	$\vdash \vdash$	To res 22 100 To Impatient 2 EN/Outpatie	ant 3 DOA 4 Nursing Ho	/	
Division of Vital	After funer	lon	1 Natural 5 ☐ Pending (Month, Day Year) Injury		Zou. Pescribe flow	injury occurred
ISIC	death ctor: y the	lical	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, s		28f. Location (Stree	et and Number or Rural Route Number,
	i girte	Serti	4 ☐ Homicide building, etc. (Specify)	, ,,	City or Town, S	State)
o d	within 24 hours after the Funeral Director of the Fune	edical (	(Check only			
, ÷	To the comp	Ž	29b. Signature and title ar Centuler	29c. License number	29d.	. Date signed (Month, Day, Year)
•		BOLTON CARROLL HARRIS   Street and Number of Paral Rouse Number, City or Town, State, Zipf Land Informant's Name Pelationship (P.), p. Print)   196. Mailing Address. (Street and Number, City or Town, State, Zipf Land Informant's Name of Land Rouse Number, City or Town, State, Zipf Land Land Rouse Number, City or Town, State, Zipf Land Land Rouse Number, City or Town, State, Zipf Land Land Rouse Number, City or Town, State, Zipf Land Land Rouse Number, City or Town, State, Zipf Land Land Rouse Number, City or Town, State, Zipf Land Land Rouse Number, City or Town, State, Zipf Land Land Rouse Number, City or Town, State, Zipf Land Land Rouse Number, City or Town, State, Zipf Land Land Rouse Number, City or Town, State, Zipf Land Ro				4/22/0006
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	For	State of Maryland / Department of Health and Mental Hygiene [ ] [ ] [	07754
-	For State Registrar	Certificate of Death Reg. No.	

Physician	ı
/Medical	ŀ
Examiner	ľ

Funera

Directo

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other then "naturel", or iteme 23a or 28a-f ehow eny injury or other treumatic event, the Medical Examiner; just be notified at

Baltimore, Maryland 21215-0036

Physician /Medica Examine

To the Hospital or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

	1 - State Registrar			Ce	ertificate	of De	eath			Reg. No.		1400	-07 4 4	
	1. Decedent's Name (First, Middle	e, Last)						2	2. Date of Dea	ath			3. Time of	Death
an	Co Tin	Im						F	Month Tebruar	v 2.8	3,200	Year )6	00:49	A M
al	Se Jin  4a. Facility Name (If not institution		imber)		4b. City, To	own or Lo	ocation of F		CDLGGI		County o			11.
er														_
	Frederick Memo			foot historia	Frede		lf Under 24	LHrs 6	3. Date of Birt				County	
	5. Social Security Number	6. Sex 1⊠M 2□F	7. Age (In yrs.	Yrs.				Min.	(Month, Da	v. Year)		Cou	place (State o ntry)	r r-oreign
	213-63-9052		44	113.				-	an. 19	, 15	962	Ko	rea	
	Usual Residence of Decedent  10a. State 10b. County		10c Cit	ty, Town or I	ocation							—	10d. Inside Ci	by Limits
-	Toa. State		100.01	ty, Town or t	Location								1 Tyes	
חומשוות	Maryland Fred	erick		Fred	lerick								1 [] 163	2 10
=	10e. Street and Number				10f. Zip C	ode				10g. Citi	zen of Wi	hat Cou	ntry?	
2	6715A Overtor	Circle	<sup>‡</sup> 2		21	703					Kore	ea		
	11. Marital Status	12. Was De	cedent Ever in U	l.S. 13	. Was Decede	nt of Hisp	anic Origin	n? (Spec	ify Yes or No	.			can Indian,	
	1 ☐ Never Married 2 ☑ Mar	Armed F ned 1 ☐ Yes	2 🔀 No		If Yes, specif		Mexican, F	Puerto R	ican, etc.)		Black	, White,		
•	3 ☐ Widowed 4 ☐ Divorced	If Yes. G	ive Dates:		1 Yes 2	XI No	Specify:				Specify:	E	Asian	
	15 Deceden	t's Education		16a. Dec	edent's Usual	Occupation	on			16b. Ki	nd of Bus	iness/In	ndustry	
h	(Specify only highe	st grade completed		(Giv	e kind of work DO NOT use	done duri	ring most o	of working	9					
	Elementary/Secondary (0-12)	College 4	(1-4or 5+)		wner/Or		or			Tra	vel A	Acen	CV	
	17. Father's Name (First, Middle,				witer / of			c Namo	First, Middle,					-
		Last								maiden	Jumanno	,		
	Yong Duk Im						Ok Ry							
	19a. Informant's Name/Relations	hip (Type, Print)		19b. Mai	iling Address (	Street and	d Number o	or Rural	Route Numbe	er, City o	r Town, S	State, Zij	p Code)	
	Kisuk Nam Im /	Wife		6715	4 Overt	on C	ircle	#2	Frede	rick	c, Ma	ry1	and 21	703
	20a. Method of Disposition			Place of Disp	oosition (Name	of	1	Da		20c. Lo	cation - C	City or T	own, State	
	1 ☑ Burial 2 ☐ Cremation 4 ☐ Denation 5 ☐ Other (S		State				3	Mar 3. 2	ch 006	Frod	laria	1- 1	Marylaı	nd
	21. Signature of Funeral Service		rre		c Crema 22. Name and									
		X A					-	bla					s, P.A	
		100			621 Opc						ck, I	Mary		
	23a. Part1. Enter the disease, or shock, or heart failure. List	r complications that only one cause on	each line.	th. Do not e	nter the mode	of dying,	such as ca	ardiac or	respiratory a	rest,			Approximate Interval Bette Onset and I	ween
	Immediate Cause (Final disease or condition	HY	refessi	in at	Levose	le von	tic 1	Carri	lier In S	ack	y -		Onset and t	Death
	resulting in death)	Due to	o (or as a consec	quence of):					alit	OCA	9			
									ars	689				
	Sequentially list conditions, if any, leading to immediate	b. — Due to	(or as a consec	quence of):	-						-			
	cause. Enter Underlying Cause (Disease or injury	<												
	that initiated events resulting in death) Last	c. Due to	o (or as a consec	quence of):										
			`											
		d										-		
	IF FEMALE:													
	23b. Was decedent pregnant		utcome of pregna birth 2  Feta		□Ectopic pre	gnancy				1 4	23d. Date Mon			Vaar
	in the past 12 months? 1 □ Yes 2 □ No	4□Preg 9□Unk	nant at time of o		Other (spec						MOH	111	Day '	Year
ļ	9 🗆 Unknown	90 ONK	nown											
	Part II. Other significant conditi	ons contributing to	death but not res	sulting in the	underlying car	use given	in Part I.		23e. Did t	obacco u	se contri	bute to t	the cause of c	death?
									1)(2)	Yes 2	□No :	3 🗌 Pro	bably 4 🗆	Jnknown
			_						04- 145-		0.45 14		C	
									24a. Was autor	SV	10	for to co	opsy findings ompletion of c	available ause of
									1X Yes	rmed? 2□ No	1)	eath? Yes	2 ☐ No	
	25. Was case referred to medica	1				. 2	26. Place o	of Death	(Check only o	ne)				
	examiner? N∑Yes 2 No	Hospital: 1	Inpatient 21	] ER/Outpati	ent 3 DOA	Other:	4 □ Nursi	ing Hom	e 5□Resi	dence	6 □Othe	r (Speci	ify)	
	27. Manner of Death	28a. Date	of Injury	28b. Time		c. Injury at Work?			Bd. Describe I			_	**	
	1 Natural 5 ☐ Pendii 2 ☐ Accident investi	19	nth, Day Year)	Injury	м		s 2 No	0						
	3 Suicide 6 □ Could	not be 280 Play	e of Injury - At h	ome farm	street factory	office		21	Bf. Location (	Street an	d Numbe	r or Ruz	al Route Num	ber
	4 Homicide determ		ding, etc. (Speci		stroot, lactory,	Onioe		-	City or To			, 0, , 10,	a, , , o a (	
	(Check only 2 T Medical	ng Physician: To the Examiner: On the	ne best of my kno basis of examina	owledge, de ation and/or	ath occurred a investigation, i	t the time, in my opin	, date and prion, death	place, ar	nd due to the dat the time.	cause(s) date and	and man	ner as a	stated. to the cause(s	s)
	one) X		nner stated.								, p. a. o. o.			
	29b. Signature and title of certifie	er -			29c.	License n	number			29d. Dat	te signed	(Month,	. Day, Year)	
	1/0/ 111	08 A			0.	C.M.	Ε.			Febr	ruarv	28	, 2006	
	30. Name and address of person	who completed ca	Ise of death (Ite	m 23a) (Tun						~_			,	
	7 ABILICE	0.00	Joo or Ubath (108)		L Penn	Stra	ot D	2-1+-	more	Marr	71 and	21	201	
	31. Date filed (Month, Pay Year		Donate Ci-		r remi	DLTE	er, D	اعدا	more,	riar)	Talic	L 41.	LUI	
	. J. Date med Infultil. Date Pedi.	7 2000	Registrar's Sign	ature .	Soul									
ie ar	MAR	n T CONP	100 -4-		A									

			For State Registrar	State of Maryland				nd Men		2000	5 (	7755	
	Physici	an			ON	TD.		l N	/onth	Day 200	ear	3. Time of Death	_
					ON D		m, or Location of		ED. 2.			1:00A	-
			Casey House					Id Use Co. es					
	Funeral Director				t birthday) Yrs.			Min. Ja	n • 29 ,	932	Coun	try)	
	and		Usual Residence of Decedent  10a. State 10b. County	10c. City, 1	Town or Lo	cation					10	0d. Inside City Limits	_
	Maryl	tor	MD Montgon	nery Ro	ckvi	.11e						1 AYes 2 □ No	
	vith the	Dire	10e. Street and Number		_				10g.			try?	
	ns 23e	eral			13. \			in? (Specify	Yes or No-	,		an Indian,	_
36	s after d or Itan	y Fun	1 Never Married	Armed Forces?  1 XYes 2 No 1953	; <b>-</b>			Puerto Ricar	n, etc.)	Black,	White,	etc.	
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d 21	filed w Hygier other tl	Col	17. Father's Name (First, Middle, Last)	6 +	Psyc	holog		's Name (Firs	st, Middle, Mai			NC	_
/lan	Mental Mental arked o	To B	Lawrence B. C	Johnson Sr.			Vio	ola B	urrell	_			
Mar	d 2 sho th and 7 Is mu traum	8 8				200430A W/				90		20310	
Baltimore, Maryland 21215-0036	Physician Medical Examiner  1. Decoder's Name (First, Middle, Last)  LAWRENCE BINGA JOHNSON JR  LAWRENCE JOHNSON JR  LAWRENCE BINGA JOHNSON JR  LAWRENCE JOHNSON JR  LAWRENCE BINGA JOHNSON JR  LAWRENCE JOHNSON JR  LAWRENCE BINGA JOHNSON JR  LAWRENCE BINGA JOHNSON JR  LAWRENCE JOHNSON JR  LAWRENCE BINGA JOHNSON JR  LAWRENCE JOHNSON JR  LAWRENCE JOHNSON JR  LAWRENCE JOHNSON JR  LAWRENCE JOHNSON JR  LAWRENCE JOHNSON JR  LAWRENCE JOHNSON JR  LAWRENCE JOHNSON JR  LAWRENCE JOHNSON JR  LAWRENCE JOHNSON JR  LAWRENCE JOHNSON JR  LAWRENCE JOHNSON JR  LAWRENCE JOHNSON JR  LAWRENCE JOHNSON JR  LAWRENCE JOHNSON JR  LAWRENCE JOHNSON JR  LAWRENCE JOHNSON JR  LAWRENCE JOHNSON J			-									
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								cardiac or res	piratory arrest,			Approximate Interval Between Onset and Death	
	Physician /Medical		disease or condition	a		IAL DI	SEASE						_
ł	Examiner		Sequentially list conditions,	b									
	uted d ansit	mine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		nce of):								
Ö,	e exectien and urial-tra	Exa			nce of):								
09/89	icate b physic s the b	edica		d									
Box	th certif lending r use a	an/Me	23b. Was decedent pregnant			Ectopic pregn	ancv					•	
o	the dea y the et ched fo	yslcl	1 ☐ Yes 2 ☐ No	4☐Pregnant at time of deat						Monti	1	Day Year	
۵.	gned by		Part II. Other significant conditions co	ntributing to death but not resulting	ng in the ur	nderlying cause	given in Part I.						
ord	requir							-					
Division of Vital Records,	The law ite hes page 2 :	omp							autopsy	Drie	or to con ath?	npletion of cause of	
/ital			examiner?	lee-itel.			A	of Death (Ch	eck only one)				_
ō	Physi or this c oral dire		1 ⊔ tes 21XNo	1 □ Inpatient 2 □ ER	b. Time of		4 🗆 1401:					Hospice	_
sion	anding sath. or: Afte	ation	2 ☐ Accident investigation	(Month, Day Year)	Injury			lo					
DIVI	al or Att efter de Direct d in by t	ertific	determined	28e. Place of Injury - At home building, etc. (Specify)	e, farm, str	eet, factory, off	fice	28f. L	ocation (Stree City or Town, S	t and Number tate)	or Rura	l Route Number,	
	24 hours Funere		(Check unity 2   Medical Exami	ner: On the basis of examination	edge, death n and/or inv	n occurred at the	ne time, date and ny opinion, deatr	place, and on occurred at	due to the caus	e(s) and manr and place, an	ner as st d due to	ated. the cause(s)	
	To the within To the comple			with material states.		29c. Lic	cense number		29d.	Date signed (	Month, I	Day, Year)	-
	5		12		)	D3	5635		F	eb. 2	7,	2006	
(3	5)						r Mill	Rd R	ockvil	le, M	ID 2	0855	
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Signatur	-								
	Registr	ar	FEB 2 8 2	2006 Janes D	-	STEP CYCLE							

			For State Registrar	State of Ma	ryland	-	rtment <i>tificate</i>			and Me	-	giene Rag. No	UUC	5 (	7756
ı	Physici /Medic		1. Decedent's Name (First, Middle, L	5						-	Date of De Month Chruur	/ 2	5 2	Year -006	3. Time of Death 02 : 05 Р м
	Examin	er	4a. Facility Name (If not institution, gi		W	STREET	4b. City, To	own, or I	Location o	of Death			CECI		
	Funeral Director		520-14-7129	Sex 7. Age	(In yrs. la:	st birthday) Yrs.	If Under 1 Months	Year Days	If Under 2 Hours	Min	B. Date of Bir (Month, Da UNC 12	th ly, Year)	923	9. Birthp Coun	lace (State or Foreign try) NC
	nyland how		Usual Residence of Decedent  10a. State 10b. County		10c. City,	Town or Lo	cation							1	Od. Inside City Limits
	the Ma	Director	MD Cecil  10e. Street and Number		Elk	rton	10f. Zip C	ode.				10g. Cit	izen of Wh	nat Coun	1 Tes 2 No
	th with		409 Skip Jack C	t.				921					SA		.,.
36	2 should be filed within 72 hours after death with the Maryland and Menial Hygiene. Is marked other then "natural", or Items 23a or 28e-f show aumatic event. It e Madical Exactive roual be no illied at	by Funerai	11. Marital Status  1 □ Never Married 2 ☑ Married  3 □ Widowed 4 □ Divorced	12. Was Decedent Ender Armed Forces? 1 X Yes 2 □ Note of the Note of the Yes, Give Year or Dates: ()	2		Vas Decede Yes, specif		spanic Orig n, Mexican Specify:	gin? (Speci , Puerto Ri	ify Yes or No can, etc.)	>-	14. Race Black,	White,	
2-00	72 hour	eted t	15. Decedent's I	Education	W II	(Give	lent's Usual kind of work	done di	uring most	t of working	7	16b. K	ind of Busi		
2121	f within liene.	Completed	Elementary/Secondary (0-12)	College (1-4or 5+	)	life. L	DO NOT use Ligeri	retired)				Re	efrig	erat	tion
pu	ed a b	Be	17. Father's Name (First, Middle, Las	,					18. Mothe	r's Name (	First, Middle,				
aryle	ges 1 and 2 should be I it of Health and Mental I if itam 27 is marked o or other traumatic eve	은	David Michael J 19a. Informant's Name/Relationship			19b. Mailin	g Address (	Street a		eva R or Or Rural F	ash Route Numbe	er, City o	or Town, S	tate, Zip	Code)
, <b>Z</b>	and 2 saith a n 27 is	8	Carrie Lee Jone	s/wife_							kton,		2192		
nore	Pages 1 nent of He int: If itar	1	20a. Method of Disposition  1  Burial 2  Cremation 3  4  Donation 5  Other (Spec				sition (Name natory or oth		-	2-28-			ocation - C	•	
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 Department of Health of Important: If item 27 I any injury or other tra		21 Signature of Funeral Service Lice		K • I •	22	. Name and	Address	s of Facility	R.T.	Foard sing S	l Fui	neral	un, Hon 2192	Maryland ne, P.A.
			23a. Part1. Enter the disease, or conshock, or heart failure. List only	y one catuse on each line	<b>)</b> .	Do not ente						-	-		Approximate Interval Between Onset and Death
ı	Pnysician /Medical	(i - j	tmmediate Cause (Final disease or condition resulting in death)	a PNEU/											
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8760,	icate be executed physician and s the burial-transit	dicai Exa	resulting in death) Last	Due to (or as a	-	ence of): ENAI	L FI	AIL	URE						
O. Box 68	ath certif ttending or use as	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome o 1 ☐ Live birth 2 4 ☐ Pregnant at ti 9 ☐ Unknown	Fetal	leath 3	Ectopic preg Other <i>(spec</i>						23d. Date Monti		ry Day Year
۵.	w requires that the de been signed by the a should be detached f		Part II. Other significant conditions	contributing to death but	not result	ting in the ur	nderlying cau	use give	n in Part I.		23e. Did t				e cause of death?
Division of Vital Records,	The law reate has bee page 2 sho	Completed							-		24a. Was autor perfo 1 \( \text{Yes} \)		pri de	ere autor or to con ath? ] Yes	osy findings available inpletion of cause of 2 No
Vita	sician: The certificate hare rector, page	Be	25. Was case referred to medical examiner?	Hospital:		D/O		Otho	***		Check only o		- 50		
on of	To the Hospital or Attanding Physician: within 24 hours after death. To the Funaral Diractor: After this certifics completely filled in by the funeral director.	ition: To	1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending 2 Accident investigati	28a. Date of Injury (Month, Day		R/Outpatien 28b. Time of Injury		c. Injury Work	at at	28	e 5 ☐ Resid d. Describe I				')
Divis	To the Hospital or Attanding I within 24 hours after death. To tha Funaral Diractor: After completely filled in by the funer	Certification;	3 Suicide 6 Could not determine	be d 28e. Place of Injur building, etc.	y - At hoп (Specify)	ne, farm, stre	et, factory,	office		28	f. Location (: City or To	Street an wn, State	nd Number e)	or Rura	Route Number,
	he Hospit in 24 hour ha Funare pletely fille	Medical (	29a. Certifying F (Check only one)	Physician: To the best of aminer: On the basis of and manner state	examination	ledge, death on and/or inv	occurred at restigation, in	t the time	e, date and inion, deat	d place, and th occurred	d due to the l at the time,	cause(s) date and	and manr d place, an	ner as st id due to	ated. the cause(s)
	To t To t	Σ	29b. Signature and title of certifier	W .	MD		1		063	3486			te signed (		Day, Year)
(	otIVA		30. Name and address of person who M, A, HAMADEH				Print)	lkto	ın, Mi	D 21	921				
	Sta Registr		31. Date filed (Month, Day, Year)  FFR 2 8 2008	32. Registrar	's Signatu	Cool	2								

Registrar

Physician Medical Examiner  Funeral Director  Social Security Number   10 Decedent's Name (First, Middle, Last)  James Johnson  4b. City, Town, Mt. Aii  Funeral Director  Fun				ental		/	06	0775	8									
			1. Decedent's Name	(First, Middle	e, Last)			***************************************							Day	Vaar	3. Time of Dear	th
			James John	ison												2006	4:10 A.	М
X					-		oer)					of Death						
											If Under Hours		8. Date (Mon. <b>May</b>	of Birth th, Day Y	914	9. Birth Cou <b>Penns</b>	place (State or For ntry) <b>ylvania</b>	eign
	pur &	The Section   The Section			10d. Inside Çity Lir	mite												
	Maryla a-f shor	James Johnson  Rectivity Name (if not institution, by the street and number)  Kline Bospice House  Kline Bospice  Kline Bospice House  Kline Bospice  Kline			1 TYes 2													
	with the	Direc			1												intry?	
	eath	era		LZ KUA		Vas Deced	ent Everin I	18 13 1			spanic Or	igin? (Spe	ofy Vas				can Indian	
36	rs after d	oy Fun	1 Neve Marrie	_	ned 1	rmed Forc ☐Yes 2 Yes, Give	es? No	1	f Yes, sp	ecify Cuba	Mexical	n, Puerto	Rican, et	c.)		Black, White		
Ö	thou stura				t's Education	n		16a. Deced	ient's Us	ual Occupa	ition			16	b. Kind o			
215	C * 100	plet					lor 5+)	(Give	kind of w DO NOT	ork done d use retired,	turing mos )	t of worki	ng				ŕ	
217	d with	ĕ	Liementary/30com	dary (0-12)			.01 547	Realt	y Of	ficer				]	Fede:	ral Go	vernment	
pue	be file ntal Hy od othe event,	Be				n								14.15	iden Sur	тате)		
aryla	ding Physician: The law requires that the death certificate be executed and 2 should be filed within 72 hours after death with the Maryland Department of Heelih and Mental Hygiene.  After this certificate has been signed by the attending physicien and Important: If them 27 is marked other then "natural", or Itams 23a or 28a-f show and principal in principal director. To Be Completed by Physician/Medical Examiner.  To Be Completed by Physician/Medical Examiner.  To Be Completed by Physician/Medical Examiner.  To Be Completed by Physician/Medical Examiner.  To Be Completed by Physician/Medical Examiner.  To Be Completed by Physician Physici						19b. Mailir	ng Addres	ss (Street a					ity or To	wn, State, Zi	p Code)		
Physician   James Johnson   James Johnson   Perunary 26, 20, 200   Perunary 26, 200   Perunar	ryland	21704																
Physician   James Johnson   Section    on - City or T	own, State																	
E	Page nent c int: If					val from St						3/2/2	006	Fre	eder	ick, M	aryland	
aĦ	rmit. porta porta y Inju		21. Signature of Fur	eral Service	Licensee		004	22	. Name a	and Addres	s of Facili	ty St	auff	er Fu	ıner	al Hom	e	
Δ.	82 = 8		_sharo	w la	null	e C	den	e 1	621 (	)poss	umtov	vn Pi	ke,	Frede	eric	k, Mar	yland 217	/02
	/Medical Examiner	lner	shock, or hear Immediate Cause (F disease or condition resulting in death)	tfailure. List Final	a	Due to (or	on line.	guence of):		1	2	-	,				Interval Between Onset and Death	
Box 6		dlcal	IF FEMALE: 23b. Was decedent in the past 12 r 1 Yes 2	pregnant	1	yes, outco □Live birt □Pregnar	ome of pregn	ancy							23d.		ery Day Year	
P.	d by i	Phy		cant condition	Ne contribu	ting to doa	th but not cor	culting in the u	adorbios	201120 5116	n in Bort I		230	Did tobac	200 1180	nontributo to 1	the earner of death	2
rds,	equires t en signe ould be c		Diabe	108		_	1.	solling in the di	derlying	Cause give	MI III F CONTI	•	256.		/			
I Reco	The law recate has be page 2 sh	Comple	Hyper	ten	+1 cm									autopsy	gl?	4b. Were auto prior to co death? 1  Yes	opsy findings available on pletion of cause 2 No	able of
Vit.	ician Sertifi ector			ed to medica		tal:				0#5		of Death	(Check	only one)				
of	S S					ı 🗀 Inp				04	4 🗀 141						M) Hospica	3
u	Jing After fune	n l	1 Natural	5 Pendir	ig	(Month,	Day Year)						200. 003	CHD <del>O</del> HOW	mijory oc	COTTOG	HOWY	0
Divisi	deat deat ctor: / the	ertifica	3 🔲 Suicide	6 Could	not be	Be. Place o building	f Injury - At h	lome, farm, str fy)								umber or Rur	al Route Number,	-
	• Hospita 24 hours • Funeral etely filled		(Check only	1 Certifyir	Examiner:	On the bas	is of examina	owledge, death ation and/or inv	occurre estigatio	d at the tim n, in my op	e, date ar inion, dea	nd place, a occurre	and due t ed at the	o the caus time, date	se(s) and and pla	d manner as s ce, and due t	stated. o the cause(s)	
	roth Mithin Foth	Me	29b. Signature and	itle of certifie					25	c. License	number			29d	. Date si	gned (Month,	Day, Year)	
	->-0				- (	Sha	oh Hi	reh -		C	516	262		0	2.2	7.06		
	7		30. Name and addre	ss of person								10		1	, ,	, 00		
	U		65	-71	ama		Lhon		Do		Fre	de.	rich.	5 /	no	ay.	702	
	Sta Registr		31. Date filed (Month	R 0 1	2006		gistrar's Sign											

			For State Registrar						t of H	ealth a		ental Hyg	iene eg. No.	06	07759
4	Physici /Medic		Decedent's Name (First, Middle     HAROLD JACOBSTE)	-								2. Date of Dea Month FEBRUAR	Day	Year 2006	8.4
A. Silver	Examin		4a. Facility Name (If not institution, 1801 EAST JEFFER			£240		4b. City,		Location o			4c. (	County of De MON	ath NTGOMERY
Ī	Funeral Director		5. Social Security Number 105–20–5605	6. Sex 1 ☑ M 2 ☐ F	7. Age		last birthday) Yrs.	If Under Months		If Under Hours	24 Hrs. g	B. Date of Birth (Month, Day APRIL 2	Year) 9, 1	9. B	inthplace (State or Foreign Country) VEW YORK
	aryland ehow	٦٢	Usual Residence of Decedent  10a. State 10b. County  MARYLAND MONTGO	MERY		10c. City	y, Town or Lo	cation	RO	CKVIL	J.E				10d. Inside City Limits 1 X Yes 2 □ No
	or 28a-f	Directo	10e. Street and Number					10f. Zip	Code			1	0g. Citiz	en ol What C	
	death w ms 23a rmust t	eral	1801 EAST JEFFEF  11. Marital Status	12. Was Dec	edent E		S. 13.	Was Deced		0852 spanic Orig	gin? (Spec	ify Yes or No- ican, etc.)	1		U.S.A. nerican Indian,
980	ours after ral', or Ita	1 by Funeral Director	1 ☐ Never Married 2 ☐ Marri 3 ☐ Widowed 4 ☐ Divorced	Armed F ed 1 Tes If Yes, G Year or I	2 XN	lo		1 Yes, spec		n, Mexican Specify:	n, Puerto Ri	ican, etc.)		Black, Wh	ite, etc. WHITE
21215-0036	is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 le marked other than "natural", or Itams 23a or 28a-f ehow other transmatic event, the Medical Examinat must be notified at other transmatic event, the Medical Examinat must be notified at	Completed	15. Decedent (Specify only highes Elementary/Secondary (0-12)	s Education grade completed College		+)	16a. Deced (Give life. I	dent's Usua kind of wor DO NOT us	rk done d	lurina mos	t of working	9		d of Busines	
d 21	filed w Hygier other th	Be Cor	17. Father's Name (First, Middle, I		+				DENT		er's Name (	First, Middle, i		PRIVAT Sumame)	<u>'E</u>
Maryland	ould ba   Mental   Marked   Marked	To B	JACOB JACOBSTEIN								IAH BI				
Mar	nd 2 sh alth and 27 le m r traum		19a. Informant's Name/Relationsh ROBERT JACOBSTE					•				Route Number			Zip Code) 20850
lore,	ges 1 a nt of Hei		20a. Method of Disposition 1 Durial 2 Coremation		State	Ce	lace of Dispo emetery, cren	natory or o	ther place		Da:				r Town, State
Baltimore,	permit. Pages 1 Department of H Importent: If ite any Injury or ot		* 4 □ Donation 5 □ Other (Sp. 21. Signature of Funeral Service L			NAT	rional 22	. Name an	d Addres	s of Facilit	ty				RCH, VIRGINIA
<u>ω</u>	g @ E & 8		23a. Part1. Enter the disease, or	complications that	hazusa	the death	1	170 R	OCKV	ILLE	PIKE,	IEMORIA ROCKV	ILLE	, MARY	LAND 20852
-	Physician		shock, or heart failure. List of Immediate Cause (Final disease or condition	nly one cause on	each lin	Θ.	CERY D			,		, , , , , ,			Interval Between Onset and Death 20 YEARS
	/Medical Examiner		resulting in death)	Due to			uence of):		-						
	utad d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b	(or as a	a consequ	uence of):								
,092	sicie sicie e bui	cal Exa	resulting in death) Last	Due to	(or as a	a consequ	uence of):						•		
Box 68	certific nding p use as 1	by Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?		birth :	of pregna 2 □ Fetal time of de	death 3	Ectopic pro					23	3d. Date of de Month	elivery Day Year
P.O.	0 0 0	hyslo	1	9□ Unkr	own			10 10 TO							
	w requires that the been signad by th should be detache	ted by	Part II. Other significant condition HYPERTENSION, DE												to the cause of death?  Probably 4 Unknown
Vital Records,	sician: Tha law r certilicate has be irector, page 2 sh	Completed										24a. Was a autops perform	V	24b. Were a prior to death?	eutopsy findings available completion of cause of
Vita	Physician: this certific ral director,	Be	25. Was case referred to medical examiner?	Hospital:	4		50/0.1-1		Othe	100		Check only on	9)		
ō	Phy this	on: To	1 [X] Yes 2 ☐ No  27. Manner of Death 1 [X] Natural 5 ☐ Pending	28a. Date			ER/Outpatien 28b. Time of Injury		Bc. Injury Work	4 🗀 140		e 5 🗓 Reside			ecity)
Division	or Attending ster death. Director: After in by the fune	Certification:	2 Accident investig 3 Suicide 6 Could n 4 Homicide determi	ot be 28e. Place	e of Inju ling, etc	iry - At ho	ome, larm, str	M eet, factory		/es 2 □ f		II. Location (St City or Town	reet and , State)	Number or F	Rural Route Number,
	To the Hospital or Attent within 24 hours after death To the Funerel Director: completely filled in by the	edical Ce	29a. Certifier 1 Certifying (Check only one)  1 Medical E	Physician: To the tament man	asis of	examinat	wledge, death tion and/or inv	occurred a	at the tim in my op	e, date and inion, deat	d place, an th occurred	d due to the call at the time, da	iuse(s) a ite and p	and manner a place, and du	is stated. e to the cause(s)
	To the Ho within 24 I To the Fu completely	Me	29b. Signature and title of certifier	0 //	7/	/	no	29c	License	number					oth, Day, Year)
•	5		30. Name and address of person	completed cau	se of de	V		Print)	טטט.	5023		1	JUKU.	21KI 23	, 2000
50.0			BRIAN SHEN, MD,			ERICK ır's Signat			AITH	ERSBU	IRG, M	IARY LAN	) 2	0877	
	Sta Registr		FEB 2 7	2006	ANG.	, S	A Black	els?				19/10 500			

			1 - For State Registrar	State of N	Marylan				ealth a Death	nd M		giene Reg. No.	006	07760
	DATE:		Decedent's Name (First, Middle, Last)							1	2. Date of De Month	ath Day	Year	3. Time of Death
	Physicia /Medic		Arne	Jacob Jo	ohnson	1					Februa		2006	7:20 P M
0.0	Examin		4a. Facility Name (If not institution, give s						Location of				inty of Death	
		ų.	Holy Cross Rehab &					rtons r 1 Year	SVille		B. Date of Bir		Contgon	Nery
	Funeral		5. Social Security Number 6. Sex	M 2□F		last birthday) Yrs.	Months		Hours	Min.	8. Date of Bir (Month, Da May 1.	1920	Cour	sachusetts
	Director		Usual Residence of Decedent		85			l			May 1,	1920	Mass	acrusects
	/land		10a. State 10b. County		10c. Cit	y, Town or Lo	ocation						1	0d. Inside City Limits
	Many s-f ah	tor	MD Howard		Wo	odsto	ck							1 Yes 2 XNo
	th the	Director	10e. Street and Number				10f. Z	p Code				10g. Citizen	of What Cour	ntry?
	death with the Maryland ms 23a or 28a-f ahow Fritter Ledtflie Jat	al	2111 Ganton Green					21163					ed Sta	
	tems	Funeral	11. Wartar Status	12. Was Deceder Armed Force	s?	.S. 13.	Was Dec	edent of H ecify Cuba	ispanic Orig in, Mexican,	gin? (Spe , Puerto	cify Yes or No Rican, etc.)		Race - Americ Black, White,	
20	hours after tural, or ite al Evaletra	by F	1 Never Married 2 Married 3 Widowed 4 Divorced	1X Yes 2 [ If Yes, Give Year or Date:	」No - 1942-	-43	1 🗌 Yes	2 <b>X</b> No	Specify:			Spe	ecity:	hite
2-003p	I within 72 hours after death with the Marylan liene. r than "natural", or items 23a or 28a-1 ahow I'ra Medical Ergiming man be cyllified at	edt	15. Decedent's Educ	cation	·· —	16a. Dece						16b. Kind o	of Business/In	
212	within 72 ene. then "nai	plet	(Specify only highest grade	College (1-4d	or 5+)	(Give	DO NOT	ork done d use retired	during most ()	of works	ng			
7	d with giene er the	Completed	cidificitary/oddoridary (o 12)	5+		Aud	litor							verment
2	be filed ital Hygi od other avent, I	Be	17. Father's Name (First, Middle, Last)								(First, Middle		name)	
ylan	should by	၉	Jacob Johnson								likaine		Ct-1- 7	0-4-1
Mar	and raum		19a. Informant's Name/Relationship (Type								I Route Numb			
	s 1 and 2 should if Health and Mer Itam 27 is marks other traumatic		Helen Lisa Johnson  20a. Method of Disposition	\mite	20b. F	Place of Dispo	osition (Na	ame of			Woodst		on - City or To	
وّ	Pages nent of I ant: If Its ary or o		1 ☐ Burial 2 🛣 Cremation 3 ☐ R	emoval from Sta	10	emetery, cre				2-27-	-2006	Cator	sville	MT
altimore,			<ul> <li>4 □ Donation 5 □ Other (Specify)</li> <li>21. Signature of Funeral Service License</li> </ul>	90 00	M010	etro Cr								ly FH Inc.
n n	permit. Departr Imports any inj		Stan Collins	withthe										MD 21043
Н			23a. Part1. Enter the disease, or complishock, or heart failure. List only or	cations that cause on each	sed the deat	h. Do not en	ter the mo	de of dyin	g, such as	cardiac o	or respiratory a	rrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition			iyeloma	1							Onset and Death
100	/Medical		resulting in death)	1.	as a conseq									
	Examiner		Sequentially list conditions,	)		-0-		_ 20.5						
	si ad	lne	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of injury	Due to (or	as a consec	(uence or):								
	and and al-tran	Examiner		Due to (or	as a conseq	quence of):								
8760	certificate be executed ording physicien and use as the burial-transit	dlcal E		1										
89	ificate g phy as the	ed												-
Вох	leath certifica attending pl	N.	23b. Was decedent pregnant	:3c. If yes, outcom 1⊟Live birth			□Ectopic	pregnancy	,			23d	Date of delive	ery Day Year
	0 0 0	sicie	in the past 12 months? 1 ☐ Yes 2 ☐ No	4□Pregnan 9□Unknow	t at time of c		Other (						MOITH	Day 16ai
0.	The law requires that the de site has been signed by the a bage 2 should be detached to	Physician/Me	9 ☐ Unknown  Part II. Other significant conditions con	atributing to dogs	h but not ree	culting in the	underhing	Cause an	en in Part I		23a Did	obacco use	contribute to t	he cause of death?
က်	ires tha signed d be del	by	Anemia	Induting to deat	n pat not res	salang in the t	andonying	oddao giv	orrant are i.	•		Yes 2□N		
Ö	v requir been si should	etec	THRAILLA								24a. Was	20 2	4h Were auto	oney findings available
Records,	has bas 39 2 s	Completed								-	auto	omed?	death?	opsy findings available ompletion of cause of
		e Co	25. Was case referred to medical						26 Place	of Deat	1 Yes	2 <b>3</b> No	1 🗌 Yəs	2€ No
5	ysicia Is cert directe	To B	evaminer?	fospital:	atient 2	] ER/Outpatie	ınt 3⊡ [	OOA Oth	00		me 5 Res		Other (Specia	fy)
o	Attending Physician: r death. ector: After this certifici by the funeral director.	n: T	27. Manner of Death	28a. Date of (Month,		28b. Time o	of	28c. Injur	y at		28d. Describe	how injury of	curred	,
0	Attending Ph or death. octor: After th by the funeral	atlo	1 Natural 5 Pending investigation	(		,	М		Yes 2□I					
Division of Vital		Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of building	Injury · At h , etc. (Speci	iome, farm, s fy)	treet, facto	ory, office			28f. Location ( City or To	Street and N wn, State)	umber or Run	al Route Number,
	To the Hospitel or Attenwithin 24 hours after death To the Funeral Director:		29a. Certifier 1 Cartifying Phy	elcien: To the b	net of mile	owladas de-	th coerre	ed at the fire	ma data a-	d place	and due to the	C31160(c) 2-	d manner as	stated
	Hos 24 ho Fun stely f	edical	29a. Certifier 1 2 Certifying Phy (Check only 2 Medical Exami	ner: On the basi	s of examina	ation and/or	nvestigati	on, in my	pinion, dea	th occur	red at the time.	date and pla	ice, and due t	o the cause(s)
	To the Hospitel within 24 hours a To the Funeral I completely filled	Me	29b. Signature and title of certifier	7 4.			2	9c. Licens	e number			29d. Date s	igned (Month,	Day, Year)
	- > - 0		taine	tallia	n			D28	8595			Febru	ary 27	, 2006
1	A		30. Name and address of person who co					_						
5)4			Tasneem Lakhani 7				æ. E	altir	more,	MD :	21208			
	St Regist	ate	31. Date filed (Month, Day, Year)	100	istrar's Sign	ature	1	4						

ORIGINAL

		For State Registrar	State	of Ma							Same Col	06	07	761
Dhusisi										Month	Day	Year	3. Tin	ne of Death
December teams (First, Morane, Land) December te	0 P <sup>M</sup>													
Examin	er		-		ital				of Death			-	1	
Euperal	7" -			-		thday)	If Under 1 Year	If Under	24 Hrs. 8.	Date of Birth			nplace (SI	tate or Foreign
		215 72 8845	1□M <b>¾</b> □F	84		Yrs.	Months Days	Hours	Min. 9/	/28/192	1	Mary	land	
D .					10c City Tow	n or Lo	cation			<del></del>			10d. Insi	de City Limits
laryla shov	5		·4		•									
the N	rect		<u>u</u>		CTALKSV					10	g. Citizen of	f What Co	untry?	
3a of			Road				21029				USA			
urs after deatl	by	1 ☐ Never Married 2 ☐ Marri	ed 1 Yes	Forces? s 2⊠N Sive						Yes or No- an, etc.)	BI	ack, White	e, etc.	an,
72 ho	eted			d)	16a.	(Give	kind of work done	Approximate relievely analogy of the surprise of pate and Number or Rural Route Pt. Ellicott City, MD 21029  Sire and Number or Rural Route or respiratory arrest, analogy analogy performed?  Columbia Pt. Ellicott City, MD 21029  Sire and Number or Rural Route Number or Rural Route Number, City or Town, State Interval Between Trease of Gash Consel and Columbia Pt. Ellicott City, MD 21029  Sire and Number or Rural Route Number of Rural Route Number or Rural Route Number, City or Town, State and place, and due to the cause(s) and manner as stated.  The time, date and place, and due to the cause(s) and manner as stated.  The time, date and place, and due to the cause(s) and manner as stated.  The time, date and place, and due to the cause(s) and manner as stated.  The time, date and place, and due to the cause(s) and manner as stated.  The time, date and place, and due to the cause(s) and manner as stated.  The time, date and place, and due to the cause(s) and manner as stated.  The time, date and place, and due to the cause(s) and manner as stated.						
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lled w tygier ther th	ပိ		ast		пс	MIEL	aker	18. Moth	er's Name (F	irst. Middle. M	Ac. County of Deeth Carroll  Year)  9. Birthplace (State or Foreign Country)  Maryland  10d. Inside City Limits 1 Year Year  10d. Inside City Limits 1 Year Year  10d. Inside City Limits 1 Year Year  11d. Race - American Indian, Black, White, etc.  Specify: White  16b. Kind of Business/Industry  Own Home  Maiden Sumame)  17d. Race - American Indian, Black, White, etc.  Specify: White  18d. Kind of Business/Industry  Own Home  Maiden Sumame)  18d. Kind of Business/Industry  Own Home  Maiden Sumame)  18d. Kind of Business/Industry  Own Home  Maiden Sumame)  18d. Kind of Business/Industry  Own Home  Maiden Sumame)  18d. Kind of Business/Industry  Own Home  Maiden Sumame)  18d. Kind of Business/Industry  Own Home  Maiden Sumame  18d. Approximate Interval Between Onset and Death 18d. Approximate Interval Between Onset and Death 2 Yrs +  18d. Approximate Interval Between Onset and Death 2 Yrs +  23d. Date of delivery Month Day Year  23d. Date of delivery Month Day Year  23d. Date of delivery Month Day Year  23d. Date of delivery Month Day Year  23d. Date of delivery Month Day Year  23d. Date of delivery Month Day Year  23d. Date of delivery Month Day Year  23d. Date of delivery Month Day Year  23d. Date of delivery Month Day Year  23d. Date of delivery Month Day Year  23d. Date of delivery Month Day Year  23d. Date of delivery Month Day Year  23d. Date of delivery Month Day Year			
d be f antal h	Be C			Certificate of Death   Section   Control   C										
should nd Me mark matic	۲	Security Personal Control   Contro												
nd 2 alth ar 27 is r trau		Gary M. Jones/S	on		11	922	Simoson	2. Date of Death   2. Date of Death   2. Date of Death   2. Date of Death   3; 30 P M   3; 30 P M   3; 30 P M   4. County of Death						
of Head		20a. Method of Disposition		m Ctata	20b. Place of	Dispo	sition (Name of					n - City or	Town, Sta	ite
Page nent c				m State	Crest				2. Date of Death   See No.   3. Time of Death   3:30 P M   3:30 P M   3:30 P M   3:30 P M   4c. County of Deeth   Carroll   Under 24 Hrs.   8. Date of Birth   Survey   See No.   See No					
permit. Departrimports Imports any inji		21. Signature of Funeral Service	d- M	0144	2									
A - 0/2		23a. Part . Enter the disease, or shock, or heart failure. List	complications that	t caused	the death. Do	not ent	er the mode of dyi	ng, such as	s cardiac or re	espiratory arre	st,		Interva	i Between
Physician		disease or condition		Prim	ary Deq	ene	rative D	ement	ia					
		resulting in death)												
Examiner	5	Sequentially list conditions,		a for an e	e consequence	offi:								
rted	i i	cause. Enter Underlying Cause (Disease or injury		(	, , , , , , , , , , , , , , , , , , , ,	,-								
execu n and ial-tra	Exal	resulting in death) Last		o (or as a	a consequence	of):								
ysicia ysicia			d										1	
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the death ce the attendi	ysician/I	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No	1 ☐ Live	e birth gnant at	2 Fetel death			у						Year
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he Hospi in 24 hou he Funer pletely fill	edical	(Check only 2 Medical	Examiner: On the	basis of	examination ar		vestigation, in my	opinion, de		at the time, da	te and place	e, and due	to the ca	
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b) 80 '		Patrick Turnes	, MD 1	000	Liberty			sburg	, MD	21784				
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DHMH 17 Rev 1/2001

			1 - For Stata Registrar	State of N	Maryland		artment o			nd Mer		giene ( Reg. No.	006	077	62
	Physici /Medic		1. Decedent's Name (First, Middle Thomas Martin	Keech Jr.						Fe	Date of Dea Month	Day y 23	3 2006	7:25	of Death P M
	Examin	er	4a. Facility Name (If not institution  Manor Care  5. Social Security Number		ar) Age (In yrs. last	hirthday	4b. City, Tov Potom If Under 1 Y	ac	tion of E		Data of Rint	Mor	County of De	у	os Consiss
i	Funeral Director		219-18-8415	1 XM 2 F	82	Yrs.		ays Hou		Min.	Date of Birtl (Month, Day		1	rthplace (State Country) Cyland	or Foreign
	aryland show	پ	Usual Residence of Decedent  10a. State 10b. County		10c. City, T								-	10d. Inside (	City Limits
	h the Mi	Director	DC Non	ie	Was	hingt	10f. Zip Co	de				10g. Citi	zen of What C		2 110
036	ould be filed within 72 hours after death with the Maryland Mental Hygiene.  arked other than "natural", or items 23a or 28a-1 show atte event, the Madical Examitrational be mailtied at	by Funerai	4000 Cathedra.  11. Marital Status  1 □ Never Married 2 Amarried 3 □ Widowed 4 □ Divorced	12. Was Decede Armed Force ied 1 14 Yes 2 (	nt Ever in U.S. s?		200 Was Decedent f Yes, specify	of Hispanio Cuban, Me	c Origin xican, F	n? (Specify Puerto Rica	Yes or No-		ted Sta 14. Race - Am Black, Wh Specify: Wh	erican Indian, ite, etc.	
Maryland 21215-0036	I within 72 ho liene. r than "natur The Madical I	Completed	15. Deceden (Specify only highe: Elementary/Secondary (0-12)	t's Education st grade completed)  College (1-4c	or 5+)	6a. Deced (Give life. 1	dent's Usual O kind of work o DO NOT use ri	ccupation one during etired)	most o	f working			nd of Busines	s/Industry  Company	7
and .	be filed ntal Hyg ed other event,	Be	17. Father's Name (First, Middle,				-				irst, Middle,		Surname)		
aryi	permit, Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 Is marked any injury or other traumatic engree.	<sup>2</sup>	Thomas Martin 19a. Informant's Name/Relations			19b. Mailin	ig Address (St				ntgome oute Numbe		r Town, State,	Zip Code)	
ē, S	Health tem 27		Mae Cecilia Ke	ech / Wife			Cathed sition (Name of natory or other		ve	NW #4			cation - City o	C 20014 r Town, State	+
Baltimore,	Pages Iment of tant: If I		1 🖾 Burial 2 □ Cremation `4 □ Donation 5 □ Other (S	pecify)	Gate	of H	leaven	Cemet						ing, M	)
Ra	permit Depar Impor any in		21. Signature of Funeral Service	Muncus									s Sons		
			23a. Part1. Enter the disease, gr shock, or heart failure. List Immediate Cause (Final	_		Do not ent	er the mode of	dying, suc	h as ca	rdiac or re	spiratory an	est,		Approxima Interval Be Onset and	tween
	/Medical Examiner		disease or condition resulting in death)	a	monia as a consequen	ce of):									
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VII	Physician: Th this certificate ral director, pag	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No	Hospital: 1 ☐ Inpa	utient 2□ER	/Outpatien	t 3□ DOA	Othor			heck only or		S □Other (Sp	ecify)	
lon or	tending Physician: death. tor: After this certifica the funeral director, p	ation; T	27. Manner of Death  1 🖾 Natural 2 🗌 Accident  2 Natural investig	g 28a. Date of li (Month, i		b. Time of Injury		Injury at Work? 1  Yes		28d.	Describe h			,	
DIVISION	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the fune.	Certification:	3 Suicide 6 Could determ	ined 289. Place of building,	Injury - At home etc. (Specify)						City or Tow	n, State)		Rural Route Nur	nber,
	ne Hosp n 24 hou ne Fune oletely fi	edical	29a. Certifier 1 Certifyin (Check only one)	g Physician: To the be Examiner: On the basi and manner	of examination	dge, death and/or inv	occurred at ti restigation, in	ne time, dat my opinion,	e and p death	place, and occurred a	due to the out the time, o	ause(s) late and	and manner a place, and du	s stated. e to the cause(	s)
		Σ	29b. Signature and title of certifie					cense num		•	2			th, Day, Year)	
	10		30. Name and address of person	who completed cause of	f death (Item 23	la) (Type,		005	عدا	5		7	- 1 1 ·	Too C	
	Sta Registr	-	Anushiravan Dad 31. Date filed (Month, Day, Year) FEB 2 (	32. Hegi	strar's Signature	-6	3219 E	xecut	ive	Terr	ace G	erma	ntown,	MD 208	374

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nding Physician: The law requires that the death certificate be executed to mining Physicians. The law requires that the death certificate be executed to mining Physician and the law requires that the death certificate be executed to make a size of the attending physician and the make and t		4a. Facility Name (If not institutio	n, give street and	number)		4b. City,	Town, or	Location of Death	1	4c. C	ounty of De	ath
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		5. Social Security Number	6. Sex 1 ☐ M 2 <b>XX</b> P		s. last birthday)	If Under Months		If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Oay	Year)	9. B	irthplace (State or Fore Country)
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	rec	10e. Street and Number	HIGHACI		Davido	10f. Zip			1	Oa. Citize	n of What (	Country?
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	era	11. Marital Status	12. Was D	ecedent Ever in	U.S. 13.	Was Deced		spanic Origin? (Sp n, Mexican, Puerto	pecify Yes or No-		Race - An	nerican Indian,
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		3 ☐ Widowed 4 🎇 Divorced	If Yes, Year o	Give r Dates:		1 🗆 Yes	2LA No	Specify:		S	pecify:	White
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	် ဂ	12			Age	nt				Rea	1 Est	ate
	Be (	17. Father's Name (First, Middle,	Last)					18. Mother's Nam	ne (First, Middle, i	Maiden Si	umame)	
	0	Bill Bailey						Hazel 1	Boggs			
		19a. Informant's Name/Relations	ihip (Type, Print)		19b. Maili	ng Address	(Street a	and Number or Ru	ral Route Number	City or 1	own, State,	Zip Code)
		Brenda King (	Niece)					ate Road		onvil	le, M	D 21035
		20a. Method of Disposition  1 XX urial 2 ☐ Cremation	3 Demoval fro	20b.	Place of Dispo cemetery, crea	osition (Nam matory or o	ne of ther plac	9)	Date	20c. Loca	tion - City o	or Town, State
2		4 Donation 5 Other (5			akemont	Mem.	Gar	dens 2-24	4-2006	Davi	dsonv	ille, MD
ਦੇ > 9	1	21. Signature of Funeral Service	Licenses		23	2. Name an	d Addres	s of Facility	II D			
<b>a a</b>		19- 9.	agram	~		12 R	idge	Funeral ly Avenu	e. Annan	.A.	MD :	21401
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cian		Immediate Cause (Final disease or condition	Ruh		Anteni	· oc Ce	e ha	- 0 Ant	Love And	ے ۸ در	18	Oncot and Dooth
iner	al Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	€ <u>. C</u> •	to (or as a consection of cons	equence of):	2mo	vyl	al Ant				weeks
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0		Part II. Other significant conditi	ons contributing to	death but not re	esulting in the u	inderlying c	ause give	n in Part I.	23e. Did tol	pacco use	contribute	to the cause of death?
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96 2	요ㅣ								24a. Was a autops perform	y	prior to death?	autopsy findings availal o completion of cause of
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director	lo Be	examiner? 1 ☐ Yes 2 No	Hospital:		ER/Outpatier				ome 5 Reside			ecny)
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death Reg. No. Date of Death Month 1. Decedent's Name (First, Middle, Last) Year **Physician** 23, 10:19™ FEB. 2006 BENJAMIN LAWRENCE KEY /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CIVISTA MEDICAL CENTER LA PLATA CHARLES If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 🛛 M 2 🗆 F Yrs. Director 216-12-3416 89 MARCH 12, 1916 MARYLAND Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits in then "naturel", or Items 23a or 28a-f ehow the Medical Examinar must be notified at 1 ☐ Yes 2 No Directo MARYLAND CHARLES LA PLATA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5275 GWYNN ROAD 20646 UNITED STATES filed within 72 hours after death Funera 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No þ Specify: 3 X Widowed 4 □ Divorced BLACK Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry at Hygiene. Flementary/Secondary (0-12) College (1-4or 5+) 8TH GRADE RIGGER FEDERAL GOVERNMENT 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) . Pages 1 and 2 should be fil tment of Health and Mental H tant: If Item 27 Is marked otf CHARLES S. KEY ADELL FRANCES BROOKS KEY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5275 GWYNN ROAD, LA PLATA, MARYLAND DIANE C. MONK / DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 2/28/06 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Important: If any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) METROPOLITAN CHURCH CEM. INDIAN HEAD, MARYLAND 21. Signature of Functal/Servior Linux THORNTON FUNERAL HOME, P.A. LYDIA C. THORNTON JOHNSON MO0583 3439 LIVINGSTON ROAD, INDIAN HEAD, MD 20640 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician CORONARY ARTERY DISEASE disease or condition resulting in death) YEARS /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) physicien and is the burial-transit The law requires that the death certificate be executed Exami that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical attending physi IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. | 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? s been signed so the d Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? s certificate has I lirector, page 2 s performed? 1 Yes 2X No 1 ☐ Yes 2 ☐ No After this certification Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No Certification; To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 Pending death. investigation 1 ☐ Yes 2 ☐ No neral Director: A filled in by the fi 2 Accident 6 Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) after 4 Homicide To the Hospital within 24 hours a To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) 29b. Signature and title of ci 29c. License number 29d. Date signed (Month, Day, Year) D-273482/23/06 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

AB (5)

State

Registrar

HOWARD M. HAFT, MD

FEB 2 8 2006

31. Date filed (Month, Day, Year)

**ORIGINAL** 

32. Registrar's Signature

12070 OLD LINE CENTER, SUITE 100, WALDORF, MARYLAND

			1 - For State Registrar	State of Mary		artment of H			ene 2.006	07765
			1. Decedent's Name (First, Middle, Last	)				2. Date of Death		3. Time of Death
	Physic /Medi		JOAN	CARC	)L	KINHAF	RT	Month March	4, 2006	2:30 AM
	Exami		4a. Facility Name (If not institution, give			4b. City, Town, or	Location of Deat	th	4c. County of Dear	
			2048 Nelson				ettsvil			ford
	Funeral Director		5. Social Security Number 6. Se 218–40–1873	x 7. Age (Ir ☐M 2MXF	n yrs. last birthday) 62 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	(Month, Day,	Year) Co	thplace (State or Foreign
			Usual Residence of Decedent		02			5/9/19	943	Maryland
	show		10a. State 10b. County	10	oc. City, Town or Lo	cation				10d. Inside City Limits
	the Maryla 28a-t shov	cto	MD. Harf	ord		Jarı	rettsvi	lle		1 ☐ Yes 2 X No
		Director	10e. Street and Number			10f. Zip Code			g. Citizen of What Co	ountry?
	£ 23	ral		n Mill Ro			21084		United	
	ter dea	Funeral	11. Marital Status  1 Never Married Married	12. Was Decedent Ever Armed Forces?	r in U.S. 13.	Was Decedent of Hi f Yes, specify Cuba	ispanic Origin? (S ın, Mexican, Puer	specify Yes or No- to Rican, etc.)	14. Race - Ame Black, Whit	
21215-0036	72 hours after death natural', or Itams 23 Joai Examinar musi	by	3 Widowed 4 Divorced	1 ☐ Yes 2 X No If Yes, Give Year or Dates:		1□Yes 2MNo	Specify:		Specify:	White
2-0	72 hours "natural", Vical Ex	Completed	15. Decedent's Edu (Specify only highest grad	reation	16a. Dece	dent's Usual Occupa	ation	rting 16	6b. Kind of Business/	
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Maryland	s 1 and 2 should be filed within 72 hours after des If Health and Mental Hygiene. Itam 27 is markad other than "natural", or Itams other traumatic event. Its Medical Examiner in	Be		14	TT 1 4-			me (First, Middle, Ma		
<u></u>	should nd Me mark matic	2	Samuel A.  19a. Informant's Name/Relationship (7)		Herbert	ng Address (Street a	Helen		rrine	Heaton
	nd 2 state at trau		Philip S. Kinha							ille, Md.
re,	f Heal		20a. Method of Disposition	2	20b. Place of Dispo				Oc. Location - City or	
E	Page nent o int: If iry or		1  Burial 2  Cremation 3  F 1  Onation 5  Other (Specify)	Removal from State	-			3/2006 P	ylesvil	le MD
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If itam 27 is any injury or othar tra <u>once</u> .		21. Signature of Funeral S Price Licens			. Name and Address			rille, Ma	
_	8978		11. Deceler	7 Tung-		E.G. Ku	rtz &	Son Fune	eral Home	e, P.A.
			23a. Part1. Enter the disease, or compleshock, or heart failure. List only o	ications that caused the ne cause on each line.	death. Do not ent	er the mode of dying	g, such as cardiad	or respiratory arres	it, 📞	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death)	a	Luns	(one	B			Some Mark
	/Medical Examiner		resulting in deality	Due to (or as a co	nsequence of					0
		Ē	Sequentially list conditions, if any, leading to immediate	Due to (or as a co	onsequence of):					
$\checkmark$	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or Injury that initiated events							
Ó	icate be executed physician and s the burial-transit	Exa	resulting in death) Last	Due to (or as a co	onsequence of):			·		
68760,	icate be physicia s the bur	edlcal		d						
	.Ξ ⊙ α	Med	IF FEMALE:							
Вох	that the death certifi ed by the attending i detached for use as	Physician/M	23b. Was decedent pregnant	3c. If yes, outcome of po 1 ☐ Live birth 2 ☐	Fetal death 3	Ectopic pregnancy			23d. Date of deli Month	very Day Year
0	0 0	yslc	in the past 12 months? 1 □ Yes 2 0 No 9 □ Unknown	4□Pregnant at time 9□Unknown	e of death 5	Other (specify)			Worth	Day Teal
۵.	ires that the signed by	/Ph	Part II, Other significant conditions con	ntributing to death but no	ot resulting in the ur	nderlying cause give	on in Part I.	23e. Did toba	cco use contribute to	the cause of death?
Records,	law requires that the as been signed by th 2 should be detache	d by				, , , , , , , , , , , , , , , , , , , ,		Yes	_	obably 4 Unknown
00	w requir s been si should	Completed						24a. Was an	24h Ware au	topsy findings available
Re	The fav	E O						autopsy performe	prior to death?	ompletion of cause of
Vital		a)	25. Was case referred to medical				26. Place of Dea	1 ☐ Yes 2 X	No 1 Yes	2 □ No
of V	Physician: this certific ral director,	To B	examiner? 1 ☐ Yes 3 ☑ No	lospital: 1 🔲 Inpatient	2 ER/Outpatien	3 □ DOA Othe	Ar.		ce 6 Other (Spec	aify)
סק			27. Manner of Death  1. □Natural 5 □ Pending	28a. Date of Injury (Month, Day Yea	ar) 28b. Time of Injury	28c. Injury Work	at ?	28d. Describe how	injury occurred	
sio	Attanding ir death. actor: After by the fune	cat	Accident investigation  3 Suicide 6 Could not be				res 2 □ No			
Division	or At after of Dirac in by	Certification:	4 Homicide determined	28e. Place of Injury - building, etc. (S	At home, tarm, stre pecify)	et, factory, office		28f. Location (Stree City or Town, S	et and Number or Ru State)	ral Route Number,
	spital		29a. Certifier Certifying Phys	sician: To the best of my	v knowledge, death	occurred at the tim	e date and place	and due to the caus	so(s) and manner as	stated
	To the Hospital or Attand within 24 hours after death To tha Funaral Diractor: completely filled in by the	edical	(Check only 2 Medical Examinate)	ner: On the basis of exa and manner stated.	mination and/or inv	estigation, in my op	inion, death occu	rred at the time, date	and place, and due	to the cause(s)
	To th withir To th comp	Me	29b. Signature and title of certifier	. 1 =		29c. License	number	29d	I. Date signed (Month	, Day, Year)
)	- 1		For Co	vans,	W	.D30	1929		3/4/2	886
(	20			mpleted cause of death	(Item 23a) (Type,	Print)	D- 6	P	- 100	21204
			7AU (L/QN)		606)	, Che	uss J	BAC	4 /M)	CICOT
	Sta Registr		31. Date filed (Month, Day, Year)	32. Pegistrar's S	Signature	and s		,		,
			MAR 1.3 20	UD BRIAL	Nr /4					

м	.017		1 - For State Registrar	•	f Marylan	d / Dep		t of H	ealth a	and M	1ental Hy	/giene Reg. No	e	6	077	56
ı	Physici	an	Decedent's Name (First, Middle, La								2. Date of D Month	eath Da		ear	3. Time of De	
	/Medie	al	NATHANIEL D. Ker				45 035	T	1	-10	March	5	20 c. County of		1617	M
7	Examir	er	4a. Facility Name (If not institution, given Spooks Hill Rd					kton	Location of	or Death			altim			
	Funeral		5. Social Security Number 6. S		7. Age (In yrs. I	ast birthday)	If Under	1 Year	If Under		8. Date of Bi	rth	9	Birtho	lace (State or F	oreian
в	Director			<b>X</b> M 2□ F	18	Yrs.	Months	Days	Hours	Min.	6/17/	1987	M	ary.	land	
	p ,		Usual Residence of Decedent  10a, State 10b, County		100 01	/, Town or Lo									0.4 1- 14- 01-14	1 - 1
	shov	j,	10a. State 10b. County  MD Harfor	ď	1	el Air								1	0d. Inside City I	
	the M	ect	10e. Street and Number				10f. Zip	Code				10a Ci	itizen of Wh	ot Cour		
	72 hours after death with the Maryland natural', or teme 23a or 28a-f show digal Examiner must be positied at	Funeral Director	72 E. Broadway					014				_	USA	at court		
	death me 23	era	11. Marital Status	12. Was Dece	edent Ever in U.	S. 13.	Was Dece	lent of Hi	spanic Ori	igin? (Sp	ecify Yes or N Rican, etc.)	0-	14. Race -			
9	or ite		1 X Never Married 2 ☐ Married	Armed For 1 Tyes If Yes, Gir	2X No		If Yes, spec 1 ☐ Yes		n, Mexicar Specify:		Hican, etc.)			White,		
93	inal',	d by	3 Widowed 4 Divorced	Year or D	ates:		10 103	2 - X/40	Specify.				Specify:		•	
5	"nati	Completed by	15. Decedent's E (Specify only highest gr			16a. Dece (Give	dent's Usua kind of wo DO NOT u	l Occupa	ition <i>uring m</i> os	t of work	ing	16b. k	Kind of Busin	ness/ind	dustry	
12	within ene. then	Jmp	Elementary/Secondary (0-12)	1 College (	1-4or 5+)	Stud		10 / 01// 00,				E	Educat	ion		
9	Hygie Other ent,	a	17. Father's Name (First, Middle, Last	)					18. Mothe	er's Name	e (First, Middle					
<u>la</u> n	Mental Mental rked c	To B	Carl W. Kenned	У					Chi	rist	ine Sto	cksc	n			
Maryland 21215-0036	2 should be filed withir and Mental Hygiene. Is marked other then eumatic event, the Ms		19a. Informant's Name/Relationship (		_		•				al Route Numb	oer, City	or Town, St	ate, Zip	Code)	
	1 and 2 Heelth em 27 l		Christine S. Ken	nedy/Mo		1			у, Ве		ir, MD	210				
Baltimore,	of Her		20a. Method of Disposition 1 □ Burial 2 X Cremation 3 □	Removal from	State	lace of Dispo emetery, cre	matory or o	ther place	e)	3/8/	Date 2006		ocation - Ci	•	wn, State	
Ë	Pag tment tant:		4 □Donation 5 □ Other (Special	<b>y</b> )	Evai	ns Eag						Le	ola,	PA	•	
Bal	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Heelih and Mental Hygiene. Important: If Item 27 is marked other then "natural", or Iteme 23a or 28a-1 show any Injury or other treumatic event, the Medical Examinar must be coulding an once.		21. Signature of Funeral Service Lice	Verre	leda		2. Name an Iarkin			-	ne, Inc	., D	elta,	PA	17314	
			27a. Tart1. Site the disease, or took shock, or heart failure. List only	plications that o	eaused the death each line.	n. Do not en	ter the mod	e of dying	g, such as	cardiac	or respiratory	arrest,			Approximate Interval Between	en
	Physician		Immediate Cause (Final disease or condition	a Hea	d and	che	st (	M	vie	N					Onset and Dea	ıın
	/Medical Examiner		resulting in death)	Due to	(or as a consequ	uence of):										
		70	Sequentially list conditions,	b. Due to	(or as a consequ	ience of):										
	red nsit	nlne	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	200.10	(0. 40 4 00,1004	201100 01).										
<b>~</b>	be executed icien and burial-transit	cal Examiner	resulting in death) Last	Due to	(or as a consequ	uence ol):										
760,	ite be iysicie ne bur	call		d												
89	wrequires that the death certificate be executed been signed by the ettending physicien and should be detached for use as the buriat-transit		IF FEMALE:													
Вох	ith ce itendii or use	an/h	23b. Was decedent pregnant in the past 12 months?		come of pregna		⊒Ectopic pi	egnancy					23d. Date of		ry Day Yea	.,
	e dea	sici	1 Yes 2 No	4∏Pregr 9∏Unkn	nant at time of de own	eath 5	Other (sp	ecify)					MOITH		Day 16a	,t
P.0	The law requires that the death certifica ate has been signed by the ettending ph page 2 should be detached for use as if	by Physician/Med	Part II. Other significant conditions	contributing to de	eath but not resu	ulting in the u	inderiving c	ause dive	n in Part I		23e. Did	tobacco	use contrib	ute to th	e cause of dea	
Records,	signé d be	d by	•	3			,	•				Yes 2			ably 4 □Unk	
Ö	v requ	Completed									24a. Was	20	24h Wa	re auto	osy findings ava	ulable
Re	he lav e has	duic						·			auto perf	opsy ormed?	prio	r to con th?	npletion of caus	e ol
	infication, pa		25. Was case referred to medical						26 Place	of Deat	1 1 Yes		1 1 1	Yes	2□ No	
<u> </u>	Physician: this certificatal director, I	To Be	examiner? 1 Types 2 In No	Hospital:	Inpatient 2	ER/Outpatie	nt 3 DC	A Othe	· C		me 5 Res		6XOther	(Specify	Scene	
Division of Vital	ng Ph ter th neral		27. Manner of Death 1 □ Natural 5 □ Pending	28a. Date (Mon	of Injury th, Day Year)	28b. Time o	of 2	8c. Injury Work	at		28d. Describe			. / •		
Si	endir. eath. or: Af	Certification:	2 Accident investigation	n March	5 2006	4:02	PM		res 🎾	No 6	diver o	fme	Collis	iss	ele ii	
ž	or Att ter de lirect	ıtlı	3 Suicide 6 Could not to 4 Homicide determined	286. Place	of Injury - At ho ing, etc. (Specify	me, farm, st	reet, factory	, office			City or To	wn. Stat	(e)		Route Numbe	,
	urs al	Ce	40.0			bad					Species			120	VIETON,	MU
	To the Hospital or Attending Physician: The lav within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	edical	29a. Certifier 1 Certifying Pl (Check only one) Medical Exa	niner: On the b	best of my kno- asis of examinat ner stated.	wiedge, deal tion and/or in	n occurred ivestigation	at the tim , in my or	e, date an sinion, dea	nd place, ath occuri	and due to the red at the time	cause(s , date an	s) and mann id place, and	er as st d due to	ated. the cause(s)	
	o the	Med	29b. Signature and title of certifier	una man			290	. License	number			29d. Da	ate signed (	Month, I	Day, Year)	
	⊢ s ⊢ ŏ		tashord	0.0	111			(	OCME			Mar	ch, 6	20	006	
	^		30. Name and address of person who	completed caus	se of death (Item	1 23a) (Type	Print)					- MAL	, O	, =0		
	10	-		nbern	4.0			l Pei	nn St	reet	Balt:	imor	e, Mai	cyla	nd 2120	)1
2	Sta	te	31. Date filed (Month, Day, Year)	20 5	legistrar's Signa	ture	e									
	Regist	ar	MAR 1 4	2006	agistrar's Signa	OF P	DOAL!									
DH	MH 17 Rev 1/2	001		de la constantina della constantina della consta											•	

			For State Registrer	State of Marylar	•	artment of h			lental Hy	giene	006	07768
			Decedent's Name (First, Middle, Las	")					2. Date of D			3. Time of Death
	Physici		William	R LYG	7214				Month FCRU	,	14 Ze	76 51054M
1	/Medic Examin		4a. Facility Name (If not institution, give	street and number)	STAR	4b. City, Town, o	or Locatio	n of Death	7 - 000		ounty of Death	
	LXuiiiii	٠.	BACTIMORE WASH		-	GLEN	Bu	RNI	15	m	W15	ARUNGET
	Funeral		5. Social Security Number 6. Se	7. Age (In yrs.		If Under 1 Year Months Days	If Und	ler 24 Hrs.	8. Date of Bi	rth	9. Birth	place (State or Foreign intry)
	Director		245-09-5025	<sup>1</sup> M <sup>2</sup> □F 86	Yrs.	Widitins Days	Tiodis	3 (4)111.	Jan. 4	, 1920	Geor	gia
	D.		Usual Residence of Decedent	140-0	v. Town or Lo							104 (-24-0): 11-1-
	how	_	10a. State 10b. County		,,							10d. Inside City Limits
	Ba-f	cto	MD Anne Ar	rundel B	rookly							1 □ Yes 2√ No
	11 12 14 14 14 14 14 14 14 14 14 14 14 14 14	Director	10e. Street and Number			10f. Zip Code	_			10g. Citize	n of What Cou	
	23a	E .	5815 Lednura Road	<del>-</del>		2122.				1	USA	
	within 72 hours after death with the Marylend ene. then "neturel", or Iteme 23e or 28e-f ehow the Modical Exerciting could be coulded at	Funerai	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	.S. 13. \	Was Decedent of I f Yes, specify Cub	Hispanic ( an, Mexic	Origin? (Sp can, Puerto	ecify Yes or N Rican, etc.)	0- 14	. Race - Amer Black, White	
36	or I	by F	1 ☐ Never Married 2 ☐ Married  3 ☐ Widowed 4 ☐ Divorced	XXYes 2 □ No lf Yes, Give Year or Dates: 1940	_4.7	1 ☐ Yes 2 🛣 No	Speci	ify:		s	pecify:	White
8	hour tural		15. Oecedent's Ed			dent's Usual Occur	pation			16h Kind	of Business/I	ndustry
<u> </u>	n 72	Completed	(Specify only highest grad	de completed)	(Give	kind of work done	during m	ost of work	ing	TOD. KING	0 0001110337	ndustry
7	than than	E C	Elementary/Secondary (0-12)	College (1-4or 5+)	Sale	s	,			Auto	omobile	<u>.</u>
0	Hygie Hygie other		17. Father's Name (First, Middle, Last)		1 5		18. Mo	ther's Name	e (First, Middle			-
Maryland 21215-0036	d be ental	To Be	William R. Lyerly	,			M	itty J	Jane Lo	uis		
2	should be filed within 72 hours after death with the Marylen and Mental Hygiene.  s marked other than "natural", or Items 23s or 28s-f show umatic event, the Medical Examinational be notified as	-	19a. Informant's Name/Relationship (7		19b. Mailir	ng Address (Street		<del>-</del>			Town, State, Z	ip Code)
S	od 2 in ar ith ar ither		Gary Elson (Perso	onal Rep.)	150	South St	reet	#200	)A. Ann	apolis	s. MD 2	21401
<u>6</u>	Head tem		20a. Method of Disposition	20b. F	Place of Dispo	sition (Name of matory or other pla		1	Date		tion - City or	
2	y or		1 ☐ Burial 2 ② Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Hemoval from State		ematory	100)	2-23-	-2006	Ralt:	imore.	MD
Baltimore,	ertme		21. Signature of Funeral Service Licen			Name and Addre	ess of Fa	cility			Imore,	110
B	permit. Pages 1 and 2 should be Deperfurent of Health and Menta Important: If Item 27 Is marked eny Injury or other traumatic events.		· Satal 1	6/16		Hardest	y Fui	neral	Home,	P.A.	MD 21	401
			23a. Part1. Enter the disease, or comp	olications that caused the deal	th. Do not ent					-	, III 21	Approximate
	Discolates		shock, or heart failure. List only of Immediate Cause (Final		11/2							Interval Between Onset and Death
1	Physician /Medical		disease or condition resulting in death)	Due to for an a consec		nowin						
	Examiner				71/100	חווב	104	,- 0	1:1	15		
	*	er	Sequentially list conditions, if any, leading to immediate	Due to (or as a consec	quence of):	1100 0	( ( ) )	_, ,-	med	120		· · · · · · · · · · · · · · · · · · ·
	d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to (or as a consect con	みつかい	OF-	CU	ilon	sic Lu	NG	D1564	5C-1
o T	exec in an	Exa	resulting in death) Last	Oue to (or as a consec	quence of):	,						
8760	Attending Physician: The law requires that the death certificate be executed rideath. sctor: Atter this certificate hes been signed by the ettending physicien and be the funeral director, page 2 should be detached for use as the burial-transit	dicai	(	d								
89	g phy as th	0										
ŏ	thet the death certific ed by the ettending p detached for use as	N/u	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Fete		Ectopic pregnanc				23	d. Date of deli	
Ω.	deatl	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 Pregnant at time of c		Other (specify)	, y 			1	Month	Day Year
Ö.	t the by th	hys	9 ☐ Unknown	9□ Unknown								
Division of Vital Records, P.O. Box	signed t	by Physician/M	Part II. Other significant conditions of	ontnbuting to death but not res	sulting in the u	nderlying cause gi	ven in Pa	ırt I.	23e. Did	tobacco use	e contribute to	the cause of death?
ğ	w require been sig should t								1 🗆	Yes 2□	No 3□Pro	bably 4 Dunknown
ပ္တ	s bed	Completed							24a. Wa	s an	24b. Were au	topsy findings available ompletion of cause of
æ	The li	E							per 1 Yes	opsy ormed? 2 No	death?	2 No
ta	an: tiffice tor, p	Be C	25. Was case referred to medical				26. Pla	ace of Deat	h (Check only			
$\geq$	yeich is cer direc	To B	examiner? 1 ☐ Yes 2 🗹 No	Hospital: 1 Inpatient 2	ER/Outpatier	nt 3 DOA Ot	her: 4	Nursing Ho	me 5 Res	idence 6	□Other (Spec	cify)
ō	9 Ph er th	2	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of	f 28c. Inju	iry at		28d. Describe	how injury	occurred	
<u>ō</u>	ath. r: Aft	atio	1 ☐Natural 5 ☐ Pending 2 ☐ Accident investigation		jury		Yes 2	□No				
<u>Vis</u>	ar de	tific	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At h building, etc. (Speci	ome, farm, str	reet, factory, office				(Street and own, State)	Number or Ru	ral Route Number,
Ö	saft saft at Dia	Certification:		,								
	To the Hospitel or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificete has completely filled in by the funeral director, page 2			ysicien: To the best of my knowiner: On the basis of examination								
	in 24 in 24 in 6 in 6	Medical	one)	and manner stated.					red at the time			
	To the Hospital or A within 24 hours after To the Funeral Directompletely filled in by	₹	29b. Signature and title of certifier			29c. Licen					signed (Monti	
			) Och	lue		$\bot$ $\Delta c$	905	370	3	1-63	WAAL	4 14,200
			30. Name and address of person who			Print)			(			4 14,200 (
			BACTIMONE WA	SUNGTON MO	- Wi Cote	cervi	en,	G	CON	BURA	10 M	13
	Sta Registi		31. Date filed (Month, Day, Year) FEB 2 7 2	32. Pigistrar's Sign	ature	6-10-						
	negisti	या	ILDA(L	UUU   P	AT L							

			1 - For State Registrer	State of Mar	-	artment of rtificate of		Mental Hy	/giene Reg. No.	)6	07769
			1. Decedent's Name (First, Middle, La.	st)				2. Date of D		Year	3. Time of Death
н	Physici /Medio		Leo Lutwak					02/23	/06 3	1041	5:08 ам
	Examir		4a. Facility Name (If not institution, give	street and number)		4b. City, Town,	or Location of Dea	ath	4c. Count	y of Death	
			Suburban Hospi			Betheso			Mon	tgome	
	Funeral Director		5. Social Security Number 6. S 057-20-6801	ex 7. Age (	(In yrs. last birthday) Yrs.	Months Days			rth ay, Year) 28	9. Birth Cou	place (State or Foreign ntry)
	D .		Usual Residence of Decedent  10a, State 10b, County		IOc. City, Town or Lo	ecation					10d. Inside City Limits
	ehov	5	Md. Montgome								1 ☐ Yes 2 ☐ No
	the N	Director	10e. Street and Number	Ly	Silver S	10f. Zip Code			10g. Citizen of	What Cou	X ntry?
	with a or	0	15107 Interlache	n Drive #50	14	2090	6				,
	me 2:	Funeral	11. Marital Status	12 Was Decedent Ev	er in U.S. 13. V	Was Decedent of	Hispanic Origin? (	Specify Yes or N		ce - Ameri	can Indian,
36	be filed within 72 hours after death with the Maryland stal Hyglene.  ad other than "natural", or iteme 23a or 28a-f ehow event, the Madical Examinat must be notified at	by Fur	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 € Divorced	Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates: 1		it Yes, specify Cu 1 ☐ Yes 2☐ No	ban, Mexican, Pue Specify:	erto Hican, etc.)	Speci	ack, White, ify: Wh	etc. ite
ğ	2 hou	ted	15. Decedent's Ed	ducation	16a. Deced	dent's Usual Occi			16b. Kind of E		
215	within 72 ene. than 'n	Completed	(Specify only highest gra	de completed) College (1-4or 5+)	life.	kind of work don DO NOT use retir	e during most of w red)	orking			
21	e filed within al Hygiene. I othar than ' vent, tha Ma	E O	2101101101101101101101101101101101101101	5+		ysician			Gove	rnmen	t
밀	be filed tal Hygi d other event, I	Be (	17. Father's Name (First, Middle, Last)				18. Mother's Na	ame (First, Middle	e, Maiden Surna	me)	
<u>ya</u>	should be nd Mental markad c	ဥ	Herman Lutwak						firstei		***
Maryland 21215-0036	les 1 and 2 should b of Health and Ments If Item 27 Is marked or other treumatic e		19a. Informant's Name/Relationship ( Diane Lutwak/Daug	Type, Print) ghter	19b. Mailir 3536	ng Address <i>(Stree</i> 12th Av	e. Brook	Rural Route Numb $1 \mathrm{yn},  \mathrm{Ny}.$	ber, City or Towr 11218	n, State, Zij	o Code)
Je,	item of He		20a. Method of Disposition		20b. Place of Dispo	sition (Name of natory or other pl	ace)	Date	20c. Location	- City or T	own, State
Ĕ	Dan Franch		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif		National		ry  02/	28/2006	Falls (	Churc	h, Va.
Baltimore,	permit. Pages 1 Depertment of H Important: If ite eny Injury or ot		21. Signature of Funeral Service Licer	s	D		ress of Facility 7–Go1dber e, Md. 20		Rockvill	e Pik	ie
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the	ne death. Do not ent				arrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition								Onset and Death
	/Medical		resulting in death)	a. Sept	cicemia consequence of):						48hours
	Examiner		Out of the first of the second		ımonia						72Hours
	D #	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events		consequence of):						
	acute ind trans	Examin	Cause (Disease or injury that initiated events resulting in death) Last	с.							
90,	cate be executed physicien and the burial-transit	ũ	resulting in deatify Last	Due to (or as a	consequence of):						
8760,	cate t	dical		d							
9 ×	eath certific ettending p I for use as	<b>4</b> 1	IF FEMALE:	23c. If yes, outcome of	pregnancy		-	-	224 5		
Box	The law requires that the death certifi se has been signed by the ettending age 2 should be deteched for use as	Physician/M	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2	Fetal death 3	Ectopic pregnan Other (specify)	су		1	ate of deliv onth	ery Day Year
P.O.	at the de by the e	ysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9☐ Unknown		_ Galor (Gpoony)					
σ.	s thet	by Pt	Part II. Other significant conditions of	ontributing to death but	not resulting in the u	nderlying cause g	iven in Part I.	23e. Did	tobacco use cor	ntribute to t	he cause of death?
rds	n sign	D D	Chronic Obstru	ctive Pulmo	onary Dise	ease		12(2)	Yes 2□No	3 🗆 Pro	bably 4 Unknown
00	law requir as been si 2 should	Completed						24a. Was			opsy findings available
æ	The lav	E						auto perf 1 ☐ Yes	ormed? 2 🔯 No	death?	ompletion of cause of
ital		0	25. Was case referred to medical				26. Place of De	eath (Check only		1 103	200110
<b>&gt;</b>	G S	To B	examiner? 1 ☐ Yes 2 H No	Hospital: 1 Inpatient	2 ER/Outpatien	it 3□ DOA O	ther: 4 Nursing	Home 5 ☐ Res	idence 6 Ot	her (Speci	<b>fy</b> )
o uo	Jing After fune		27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day )	28b. Time of Injury	W	ury at ork? ☐ Yes 2 ☐ No	28d. Describe	how injury occu	rred	
	or Attenater deall Director: In by the	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury building, etc.	/ - At home, farm, str (Specify)	eet, factory, office	•		(Street and Num own, State)	ber or Rur	al Route Number,
	Hospite 4 hours Funeral ely filled		(Check only 2 Medical Exar	ysicien: To the best of niner: On the basis of e	xamination and/or in-	n occurred at the vestigation, in my	time, date and place opinion, death occ	ce, and due to the	cause(s) and m	nanner as s	stated, to the cause(s)
	within 2 within 2 To the i	Medical	one) 29b. Signature and title of certifier	and manner state	.Dd.		nse number		29d. Date sign		
	20		Michael a	. Westers	non, M.D.				_	23/06	Day, roar
	0		30. Name and address of person who Michael A. Weste		th (Item 23a) (Type, box 2316 R		on, md. 2	20891-23	16		
	Sta Registr		31. Date filed (Month, Day, Year) FEB 2 7 2	32 Registrar	s Signature	arke					

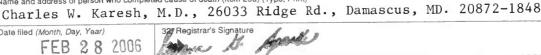
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1 Decedent's Name (First, Middle, Last) **Physician** 4:00 AM 23, February 2006 McCalley Virginia G. /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery Rockville National Lutheran Home 8. Date of Birth (Month, Day, Year) Apr. 18, 1909 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number Days **Funeral** Months Pennsylvania Hours 96 Yrs 579-01-0233 Director Usual Residence of Decedent 10d. Inside City Limits 10b County 10c. City, Town or Location 10a State 28a-f show other traumatic event, the Medical Examiner must be notified at 1X Yes 2 No Rockville Director Montgomery 10g. Citizen of What Country? 10f. Zin Code 10e. Street and Number 5 USA 20850 9701 Viers Drive permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene important: if item 27 is marked other than "natural", or items 23a any nijury or other traumatic event, the Middeal Examples 1900. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: White 3 ₩idowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NDT use retired) Elementary/Secondary (0-12) Colfege (1-4or 5+) Own Home Home Owner 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Madge Beckett Horace Courtland Bailey 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3929 Kincaid Terrace, Kensington, Md. 20895 Charles W. McCalley/Son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 Fernation 3 Removal from State Feb.24, 2006 Alexandria, Va. Metropolitan Crem. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature Frenal Service Lens 22. Name and Address of Facility DeVol Funeral Home 2222 Wisconsin Ave., NW., Washington, DC 20007 MAU 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as complications arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Mon W Immediate Cause (Final disease or condition resulting in death) Physician /Medical to (bras a consequence of): **Examiner** 1-ears 20 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner The law requires that the death certificate be executed the burial-transit Due to (or as a consequence of) Box 68760. attending p for use as as *IF FEMALE* 23d. Date of delivery 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de: 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy Year Month Day in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) P.O. ed by the a 9 Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. þ brillation 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed has Yes 2 No 1 Yes 2 No certificate Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death Check onlone Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA Other: ursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ № 2 this 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 27. Manner of Beath 28a. Date of Injury (Month, Day Year) After t Certification: 1 Matural 5 Pending 1 🗌 Yes death. investigation 2 Accident Director: 6 Could not be 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Pface of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 T Homicide within 24 hours a 10 ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

State Registrar

31. Date filed (Month, Day, Year) FEB 28 2006

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signatur and title of certifier



To the

29c. License number

29d. Date signed (Month, Day, Year)

State Registrar

FEB 28 2006

31. Date filed (Month, Day, Year)

32 Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death February 22, 2006 **Physician** McClure 11:25 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 4680 Pisgah Marbury Road Marbury Charles If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year Jan. 18, 1 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 ☐ M 2 🛣 F 216-50-7419 Yrs. Director 78 1928 Kentúcky Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or iteme 23a or 28e-f show any injury or other traumatic event. It is Medical Examination to redified at ORCE. 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No by Funeral Director Maryland Charles Marbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4680 Pisqah Marbury Road 20658 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: White 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Receptionist U.S. Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Troy Dobson Addie Fugate 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dana Kline Daughter 633 Admiral Dr., #9107, Annapolis, Md. 21401 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 25, 2006 Trinity Memorial Gardens Waldorf, Maryland 22. Name and Address of Facility
Williams Funeral Home, P.A. 21. Signature of Funeral Bervice Licenses M00668 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 4270 Hawthorne Rd., Indian Head, Md. 20640 Approximate Interval Betw Immediate Cause (Final disease or condition resulting in death) PANCREA **Physician** /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed physicien and s the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown Month 4☐Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? TES-TYPE-2 2 No 3 Probably 4 □Unknown 1 ☐ Yes ERTENSION 24a. Was an autopsy performed?
1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No certificate 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one Hospital: 1 Inpatient 2 EP/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No ٩ this After thi 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation death. 1 ☐ Yes 2 ☐ No Director: 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours after To the Funeral Dire Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0026064 02-23-2006 10583-THEODORE GREEN BUVD WHITE PLAINS, MD- 20695 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) VIDYASAGAR ANMANGANDLA 32. Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrat Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Day **Physician** Henry Bryant Matthews /Medical February 28 2006 6:40 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Homewood Nursing Home Williamsport Washington County 8. Date of Birth (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min. **Funeral**  Birthplace (State or Foreign Country) 1 XM 2 ☐ F Yrs 85 Director 21 1920 214-16-0053 Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits other then "naturel", or Items 23a or 28a-f show 1 ☐ Yes 🏖 ☐ No Washington Directo Maryland Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11109 Pinewood Circle 21742 Funeral U.S.A. 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Specify White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NDT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Insurance Company Insurance Agent permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: If Item 27 is marked other eny lingury or other traumatic event 2008. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Samuel O. Matthews, Sr. ၉ Laura Agnes Lewis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rosalie W. Matthews (wife) 11109 Pinewood Circle Hagerstown Maryland 21742 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 

Burial 2 □ Cremation 3 □ Removal from State Rose Hill Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 3-3-06 Hagerstown Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Douglas A. Fiery Funeral Home XUUCO Lin 1331 Eastern Blvd. N. Hagerstown Maryland 21742 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart/failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) VIteria scleso Ka **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed attending physicien end for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Year Day 4☐Pregnant at time of death 9☐ Unknown signed by the all d be detached for 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by should 1 ☐ Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 22 No certificate 1 Yes or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital 28 No Other: 1 🗌 Yes 1 🔲 Inpatient 2 ER/Outpatient 3 DOA 4√ Nursing Home 5 Residence 6 Other (Specify) After this 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification; 5 Pending 1 Natural
2 Accident after death. investigation 1 Yes 2 No illed in by the 3 Suicide 6 Could not be determined 28e. Ptace of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide within 24 hours after To the Funeral Direct To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely i 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) oss of person who completed cause of death (Item 23a) (Type, Print) hin, Day, auxsylves Year) 32. Registrar's Sig State MAR 0 Registra

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1 - For State Registrar	State of	Maryland / De	partment d ertificate			ene g. No. 06	07774
		98	1. Decedent's Name (First, Middle, Last)					2. Date of Death Month		3. Time of Death
	Physici /Medi		BARRY MCA	LLISTER				FEBRUARY	-	06 00:00 A
j.	Examir		4a. Facility Name (If not institution, give		oer)	4b. City, Tov	m, or Location of Dea		4c. County of	
			FREDERICK MEMO	RIAL HOS	SPITAL	FREDER	RICK		FREDER	ICK
-5	Funeral		5. Social Security Number 6. Sec	7.	. Age (In yrs. last birtho	ay) If Under 1 Y				Birthplace (State or Foreign Country)
	Director		216-54-8129	M 2□F	56 Yrs	· Months Da	ays Hours Mil	Nov. 28	, 1949	Maryland
	P.		Usual Residence of Decedent							
	ehow	_	10a. State 10b. County		10c. City, Town o					10d. Inside City Limits
	Be-f	cto	Maryland Washing	ton		Clear S	pring			1 Yes 2X No
	or 24	Director	10e. Street and Number			10f. Zip Co		10	g. Citizen of Wha	
	23a	62	14521 National Pi	.ke		2.	1722		US	6A
21215-0036	be filed within 72 hours after death with the Maryland tal Hygiene.  Id other then "natural" or items 23s or 28e-f ehow event, the Medical Examinar must be rotified at	by Funeral	11. Marital Status  1 □ Never Married 25 Married  3 □ Widowed 4 □ Divorced	12. Was Deced Armed Forc 1 Tes 2 If Yes, Give Year or Date	es? ⊠No	3. Was Decedent If Yes, specify 1 Yes 2 🛛	of Hispanic Origin? ( Cuban, Mexican, Pue No Specify:	Specify Yes or No- rto Rican, etc.)		American Indian, White, etc. white
Ö	2 ho	Completed	15. Decedent's Edu	cation	16a. De	cedent's Usual O	ccupation	. 1	6b. Kind of Busir	ness/Industry
715	nin 7.	ple	(Specify only highest grade Elementary/Secondary (0-12)	e completed) College (1-4	lor 5+)	ive kind of work d e. DO NOT use re	one during most of w etired)	orking		
212	filed with Hygiene. Ither ther ont, the M	E 0	12	0	pro	duction	supervisor		truck m	ıfg.
b	i Hygid other	Be C	17. Father's Name (First, Middle, Last)		,		18. Mother's Na	ame (First, Middle, M	laiden Sumame)	
a		To B	Leon McAllister				Lorra	ine Gordo	n	
Maryland	2 shou and N ie man	-	19a. Informant's Name/Relationship (Ty	pe, Print)	19b. M	ailing Address (St	reet and Number or F	Rural Route Number,	City or Town, Sta	ate, Zip Code)
	12 = 2		Lisa McAllister -	wife	14.	521 Natio	onal Pike,	Clear Sp	ring, Ma	ryland 21722
Baltimore,	s 1 and 2 if Health item 27 i		20a. Method of Disposition		20b. Place of Di	sposition (Name o	of colonal	Date 2	Oc. Location - Cit	ty or Town, State
e E			1 ☐ Burial 2 X Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)		ate	own Crem		2/06 н	agorator	wn, Maryland
₹	그는 근 등		21. Signature of Funeral Service License		nageist	22. Name and A	ddress of Facility	MINNICH F	UNERAL H	IOME
B	Departiment Departiment Departiment Departiment Department	13/1	MA	11. march			d., Hagers			
	-		23a. Part1. Enter the disease, or compl shock, or heart failure. List only or	ications that cau	used the death. Do not	-				Approximate Interval Between
38760,	Physician //Medical Examiner the pnriat-fransit	al Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to lo.	r as a consequence of):  as a consequence of):  r as a consequence of):	pathy				Onset and Death
687		edical		J.						1
.O. Box (	The law requires that the death certifi ate has been signed by the attending page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 ☐ Live birt	ome of pregnancy h 2 Testal death nt at time of death m	3 ☐ Ectopic pregn 5 ☐ Other (specif			23d. Date of Month	•
Δ,	that led b deta	P	Part II. Other significant conditions con					23e. Did toba	acco use contribu	ute to the cause of death?
ds,	uires sign ld be	d by	Trening	ihis -	recent	Illness		1 🗆 Yes	s 2 🗆 No 3 (	☐ Probably 4 ☐Unknown
Ö	w requ	Completed	Ventrica	Island	- Yellan	- Illuda	5.	24a. Was an	24 10/0	re autopsy findings available
3e	has has	E D	Ven Louis	11115	- ( ( ( ( ( ( ( ( ( ( ( ( ( ( ( ( ( ( (	771.1(65		autopsy	prio	or to completion of cause of
<u>_</u>	r: The l									Yes 2□ No
Z.	ician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	lospital:		-	26. Place of Do	eath (Check only one	)	
of Vital Record	phys this al dii	은	Yes 2 No  27. Manner of Death	28a. Date of		tient DOA	4 ☐ Nursing	Home 5 Resider		(Specify)
	ding F h. After funer	Certlflcation:	1 Natural 5 ☐ Pending	(Month,	Injury 28b. Tim Day Year) Inju		Injury at Work?	28d. Describe how	w injury occurred	
Sic	Attendi death. ctor: A	cat	2 Accident investigation 3 Suicide 6 Could not be				1 ☐ Yes 2 ☐ No	00(1		
Division	or Attending ifter death. Director: After in by the fune	듣	4 Homicide determined	289. Place of building	f Injury - At home, farm j, etc. <i>(Specify)</i>	, street, factory, of	fice	City or Town,		or Rural Route Number,
	Hospitei 4 hours a Funerail	Medical Ce	29a. Certifier Certifying Phy. (Check only one) 2 Medical Exemi	sician: To the b ner: On the bas and manne	est of my knowledge, dis of examination and/our stated	eath occurred at the rinvestigation, in	ne time, date and placemy opinion, death oc	ce, and due to the car curred at the time, da	use(s) and mann te and place, and	er as stated. I due to the cause(s)
	ro the within 2 Fo the complex	Me	29b. Signature and title of certifier			29c. Li	cense number	29	d. Date signed //	Month, Day, Year)
	F 3 F 8							1	1 1	
7			· In				006041	/ 2	-125/4	2000
21	1-10		30. Name and address of person who co	ompleted cause	of death (Item 23a) (Ty 5-C Thom	pe, Print)	MC	7 4 L	104 442	217/1)
	- 10		Hemen Shah ~	15 . 65 32 Ber	gistrar's Signature	ices jour	VISON DY	. 4 VTAEV	ICE MID	2110
-	Sta	пе	FFR 2.8 21	106	J. S. S. S. S. S. Materio	1 .1.				

Amend Item: 8 per F.H G-856 6/21/06 reb
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

			1 - For State Registrer	State of	Maryland / De <i>C</i>	partment of e <i>rtificate o</i>		_	giene	6 0	7775
			1. Decedent's Name (First, Midd	le, Last)				2. Date of De	ath		. Time of Death
	Physic /Medi		Goldie Elizabe	eth MACE				Februa	ry 26, 2	Year	2 OCAM
	Exami		4a. Facility Name (If not institution	n, give street and numb	oer)	4b. City, Town	, or Location of		4c. County		
			10936 Larch Av	7enue			erstown		Wash	ington	
	Funeral		5. Social Security Number	6. Sex 7.	Age (In yrs. last birthda	y) If Under 1 Yea Months Day	s Hours	Min. (Month, Da	th 10/25		(State or Foreign
	Director		234-64-9972 Usual Residence of Decedent	10.11112	89 Yrs.			0ct. 1	5, 1916	West V	irginia
	land		10a. State 10b. County	/	10c. City, Town or	Location				10d. li	nside City Limits
	Mary 4 sh	ğ	Maryland Was	shington	Нао	erstown					1∐Yes 2⊠No
	the	rec	10e. Street and Number		1108	10f. Zip Code			10g. Citizen of W	/hat Country?	<del></del>
	h with	Funeral Directo	10936 Larch A	venue			21740		US.	,	
	deat	ner	11. Marital Status	12. Was Decede	ent Ever in U.S.	3. Was Decedent of		n? (Specify Yes or No Puerto Rican, etc.)	- 14. Race	- American In	ndian,
9	after or Ite	F	1 ☐ Never Married 2 ☐ Mar	ried 1 Yes 2	XNo	If Yes, specify Cu		Puerto Rican, etc.)		k, White, etc.	
933	ural',	d by	3 ☑ Widowed 4 ☐ Divorced	Year or Date	es:	TO THE ZUXIN	o Specify:		Specify:	whit	e
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	filed withi Hygiene. other than ent, the M	e Co	17. Father's Name (First, Middle,		0	wner	18 Mother's	s Name (First, Middle,		iture s	store
Maryland	iges 1 and 2 should be filed within 72 hours after death with the Marylan nt of Health and Mental Hygiene.  If item 27 is marked other than "natural", or items 23s or 28e-f show or other traumatic event, the Medical Eventual Entitle at	To B	John Roach Co					nnie Clark	Walder Jamanie	=/	
ary	2 shou and N Is mai		19a. Informant's Name/Relations	ship (Type, Print)	19b. Ma	iling Address (Stree	et and Number	or Rural Route Numbe	er, City or Town, S	State, Zip Code	le)
	ss 1 and 2 of Health a item 27 Is r other tra	Γ.	Patricia M. Le	onard - dau	ighter 10	936 Larch	Ave.,	Hagerstown	n, Maryla	and 217	740
ore	of He fiten		20a. Method of Disposition 1 Burial 2 ☐ Cremation	3 Damoual from St.	20b. Place of Dis	position (Name of rematory or other p	-	Date	20c. Location - (		
Ë	Part and		'4 □Donation 5 □Other (S			lasonic C		3/3/06	Weston,	West	Virginia
Baltimore	permit. Page Department o Important: If eny injury or once.		21. Signature of Funeral Service	Licensee		22. Name and Add			I FUNERAL		
_	ă05 5 d		(Balut &)	anher				Lvd., Hager		Md. 217	740
			23a. Part1. Enter the disease, or shock, or heart failure. List	r complications that cause on each	sed the death. Do not e h line.		,		1 1	Inter	roximate rval Between
	Physician	0.1	Immediate Cause (Final disease or condition	_a. A	teriosch	10/11 C	adi	ovaccall	andre	Ons	set and Death
	/Medical Examiner		resulting in death)	Due to (or	as a consequence of):						
		ē	Sequentially list conditions,	b. Due to for	as a consequence of).						
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Вох	death certifii e attending p od for use as	an/l	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcor 1 ☐ Live birth		□Ectopic pregnan	cv			of delivery	
	0 0 2	Physician/Me	1 Yes 2 No	4□Pregnant 9□ Unknowr	t at time of death 5	Other (specify)			Mont	th Day	Year
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		n; T	27. Manner of Death	28a. Date of Ir	njury 28b. Time	of 28c. Inju	ury at	ing Home 5 Residence 128d. Describe he	ow injury occurred		
Ö	Attending I death. ctor: After y the funer	atlo	1 Natural 5 ☐ Pendir 2 ☐ Accident investi	9	Day Year) Injury		ork? ]Yes 2.∏No				
Division	r Atte er de recto by th	Certification:	3 ☐ Suicide 6 ☐ Could determ	inca   286. Place of	Injury - At home, farm, s	treet, factory, office	1	28f. Location (Si City or Town	treet and Number	r or Rural Roul	te Number,
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	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the fune	edical	29a. Certifier 1 Certifyir (Check only one) 2 Medicel	ng Physicien: To the be Examiner: On the basis	or examination and/or i	th occurred at the t	ime, date and popinion, death	place, and due to the coocurred at the time, d	ause(s) and mani late and place, an	ner as stated.	cause(s)
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			30 Name and address of person	who completed oadse o	f death (Item 23a) (Type	Print)	0	(1)	JI Magic	y - 1	cus
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene | Certificate of Death Reg. No. 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day 96 **Physician** 1557 ¤ CALLOS 02 06 /Medical 4c. County of Death (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner HAgesbun Wastingla Count 4 Wostlinglan If Under 1 Year If Under 24 Hrs. Age (In yrs. last birthday 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours Days 1 □ M 217-09-9823 86 Director New York Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. snt: If Item 27 Is marked other then "natural", or items 23a or 28a-f ehow 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits traumatic event, the Medical Examiner quet be natified at 1 XYes 2 ☐ No Director Williamsport Washington 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code **USA** 16505 Virginia Ave. Apt. 313 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black. White, etc. 1 Never Married 2 Marned ☐Yes 2 Yes, Give 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: þ White 3 X Widowed 4 ☐ Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 th Credit Manager Banking 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be George John Callas Pellagea Stratis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17915 Golf View Dr. Hagerstown, MD 21740
ce of Disposition (Name of Date 20c. Location City of Date Catherine G. Lewis / Neice 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of H Importent: If Ite any injury or ot ance. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 2/28/06 4 ☐ Donation 5 ☐ Other (Specify) Rose Hill Cemetery Hagerstown, MD 22. Name and Address of Facility Gerald N. Minnich Funeral Home 21. Signature of Fune al Service Licensee 305 N. Potomac St. Hagerstown, MD 21740 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner egionella DNEUMONIAE SEDGIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed nello KINOMUSMO ettending physicien and for use as the burial-trar resulting in death) Last (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medicai IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? has death? 1 ☐ Yes 2 No 1 Yes 25. Was case referred to medical 26. Place of Death Check only one Hospital: Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3□ DOA 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: After 5 Pending Injury after death. 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) hours after vithin 24 hou.

\*\*he Funeral D'

\*\*Hed Curtifying Physician: To the best of my knowledge, death occurred at the time date and class, and due to the sauss(s) and manner as stated edical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifies pleted cause of death (Item 23a) (Type, Print) HOSPITALIST OFFICE

32. Registrar's Signature 54-4 BARON 31. Date liled (Month, Day, Year) State 28 2006 Registrar

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Amended item 4a per dr/wich@ertificate of Death02-28-2006/dabsho. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death , Day 23, **Physician** Month 2006 6:10AM February /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Berlin Nursing and Rehab 25 -0 If Under 24 Hrs Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral Months Days Hours Min 212-72-1582 Usual Residence of Decedent 1 M 2 □ F Director 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or Items 23a or 28e-f show other traumatic event, I're Medical Examiner must be notified at 1 ☐ Yes 2 ₺No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8 15820 .0 a0 Funeral 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) . Race - American Indian, 11. Marital Status 1 DXYes 2 No 194 9
If Yes, Give
Year or Dates: / G ... — Black, White, etc. 1 ☐ Never Married 2 ☐ Married 21215-0036 1 ☐ Yes 2 🕱 No Specify: þ Specify: 3 Widowed 4 □ Divorced lack Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) ZNO rade havi Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 1 and 2 should be SUN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Important: If item 27 la eny injury or other trac Health 20b. Place of Disposition (Name of pemetery, crematory or other place) Darren Jord Nor 500 10 Baltimore, 20a. Method of Disposition Date 20c. Location 1 Murial 2 ☐ Cremation 3 ☐ Removal from State ' 4 ☐Dongtion 5 ☐ Other (Specify) Cm ea 22. Name and Address of Facility BCNNIC 21. Signature of Funeral Service Licensee Smith P.O. Box 33 ound Pocemoko 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Retween Immediate Cause (Final disease or condition resulting in death) Onset and Death **Physician** and consecular eevs /Medical Due to (or as a consequence of): Examiner ew Y Certive Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-transit The law requires that the death certificate be executed and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, nding physician Physician/Medical the th as esn 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery atter 3 DEctopic pregnancy for Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a Id be detached for 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 ☐ Probably 4 ☐ Naknowr 1 ☐ Yes 2 ☐ No been si should 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an page 2 autopsy performed? (es 2 No certificate 1 ☐ Yes or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: Nursing Home 5 Residence 6 Other (Specify) 2 1 Inpatijent 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) within 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral 28b. Time of Injury 27 Manner of Death 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 SNatural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

FEB 2 8 2006

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Moore,

32. Pogistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene | | | 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** Betty Hurley Majors February 28,2006 11:25A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Dorchester General Hospital Cambridge Dorchester If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days Hours 1 □ M 2 🔀 F Yrs. 213-24-4781 Nov 5,1929 Maryland Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits XXYes 2 □ No Director Maryland Dorchester Hurlock 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 45 Delaware Avenue 21643 US Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes XXNo Specify: Specify: White 3℃ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 11 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Milton M. Hurley Effie Mae Gray 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ruth Donaldson Daughter 401 Atlantic Avenue Cambridge, Maryland 21613 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Elliott Churchyard 03/04/06 Elliott, Maryland 22. Name and Address of Facility
Thomas Funeral Home, P.A. 21. Signature / Funeral Service Licensee 700 Locust Street Cambridge, Maryland 21613 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of). Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of): Be Completed by Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 Tho
9 Unknown 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Des 2 □ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autop. performed: Atrial tibrillation 1 🗆 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: → Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification; To 27. Manner of Death

1 Natural

2 Accident 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Pending 1 ☐ Yes 2 ☐ No investigation Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a Certifier 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) my en who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

**Funeral** 

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After Attending

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Physician:

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To the Hospital within 24 hours a To the Funeral I

The law requires that the death certificate be executed

Records, P.O.

Division of Vital

Baltimore, Maryland 21215-0036

?? is marked other than "natural", or Items 23a or 28a-1 ehow traumatic event, Ite Madical Examinat must be notified at

32.

2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 10 1 - For State Registrat Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician William Luther Murray 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington County Hospital Hagerstown Washington If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 → M 2 □ F 92 214-09-8334 Yrs. Director MD Nov Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits rai', or items 23a or 28a-t show Examiner nust be notified at Director 1 ☐ Yes 2X No Franklin Waynesboro 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10605 Susquehanna Avenue 17268 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. 1 Never Married 2 Married ☐Yes 2 🕅 No Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No White Specify: Completed by 3 XWidowed 4 Divorced "natural" Year or Dates: the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. ant: if item 27 is marked other then ury or other treumetic event, the Ma Elementary/Secondary (0-12) College (1-4or 5+) Foreman Manufacturing Co. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be William H. Murray Mary J. Hurd 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carrolleen L. Hunt 10605 Susquehanna Ave. Waynesboro, PA 17268 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Cumber Tand Valley permit. Page Department of Important: If any injury or Mar 7, 2006 Waynesboro, PA 17268 4 □ Donation 5 □ Other (Specify) Crematorium 22. Name and Address of Facility Grove-Bowersox Funeral Home, Inc. 21. Signature of Funeral Service Licensee 100ce 50 S. Broad St. Waynesboro, PA 17268 23a. Part1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition ME MWan a resulting in death) /Medical Due to (or as a consequence of) Examiner congestive Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Completed by Physician/Medical Examiner Hospitel or Attending Physicien: The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. es the IF FEMALE esn 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy o in the past 12 months? Month Day Year signed by the al 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown should 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 s 1 Yes 2 X No director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? After Injury 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 TYes 2 TNo 2 Accident investigation 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 032327 5 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

			For State Registrar	State of Marylar				lealth ai D <i>eath</i>	nd Me		iene <sub>eg. No.</sub> 0	06	07780
	Physici	an	1. Decedent's Name (First, Middle, Las Saad Ibn Muhi			_				Date of Deat		2006	3. Time of Death 6:30P. M
	/Medic Examin		4a. Facility Name (If not institution, give Laurel Regional He	e street and number)			, Town, or	Location of			4c. Co	unty of Death	<u></u>
	Funeral Director		5. Social Security Number 6. S	ex 7. Age (In yrs.	last birthday) Yrs.	If Unde Months	Pays	If Under 24 Hours	4 Hrs. 8	Date of Birth	2006	9. Birthp Mar	lace (State or Foreign
	Maryland	tor	Usual Residence of Decedent  10a. State 10b. County  Maryland Prince Ge		ity, Town or Lo							1	0d. Inside City Limits 1 ☐ Yes 2 No
	death with the Maryland me 23a or 28e-f ehow rmust be notified at	Funeral Director	10e. Street and Number 11433 Cherry Hill	Road, #101		10f. Zi	p Code	20705	н	1	og. Citizer Unite	of What Cour ed State	es
920	urs after al', or ite Exemine	þ	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forcas? 1 □Yes 2√ No If Yes, Give Year or Dates:	ŀ	Was Dece If Yes, spe	**	ispanic Origi in, Mexican, Specify:	in? (Speci Puerto Ri	fy Yes or No- can, etc.)		Race - Americ Black, White,	etc.
Maryland 21215-0036	is 1 and 2 should be filed within 72 hours of Health and Mental Hygiene. Item 27 is marked other then "natural; other traumatic event, the Madical Ex-	Completed	15. Decedent's E. (Specify only highest gra	ducation de completed) College (1-4or 5+)	16a. Dece (Give life. non	kind of wo DO NOT i	ork done d	during most o	of working		16b. Kind	of Business/Ind	dustry
/land	2 should be filed and Mental Hyg ie marked othe raumatic event,	To Be C	17. Father's Name (First, Middle, Last) Muhib	Rahman				18. Mother Ayesl		First, Middle, I	Maiden Su		ntar
	and 2 sho salth and h n 27 le ma er trauma		19a. Informant's Name/Relationship ( Muhib Rahman -fat	her	11433	Cher	ry H	ill R				own, State, Zip 11e, M	code) aryland2070
Baltimore,	Page nent c ant: If ury or		20a. Method of Disposition 1 ØBurial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specific	Inemoval from State	Place of Dispo cemetery, cred orge Wa	sition (Na natory or shing	me of other plac ston	Cemet	ery 3	E.,		ion - City or To	wn, State aryland
Balt	permit. Departr import. eny inj		21. Signature of Funeral Service Licer	Voma	D 4	onald 400 I	owde	Borgwar Mil	ardt 1 Roa	Funera d Belt	l Hom svill	ne, PA e, Mar	yland 20705
	Physician /Medical Examiner	ner	23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury	one cause on each line.  Cardiopuln  Due to (or as a conse  Heart Fail  Due to (or as a conse	nonary quence of):	arres	st .	g, such as c	ardiac or r	espiratory arre	est,		Approximate Interval Between Onset and Death
8760,	cate be executed ohysician and the burial-transit	dicai Examine	Cause (Disease or injury that initiated events resulting in death) Last	c. Congenital  Due to (or as a conse		Dise	ease						
P.O. Box 68	ne death certifi the attending p	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregn 1 □ Live birth 2 □ Fet 4 □ Pregnant at time of 9 □ Unknown	al death 3	DEctopic p					23d	. Date of delive Month	ry Day Year
ds, P	juires that the signed by ald be detacted.	d by Pr	Part II. Other significant conditions of	ontributing to death but not re	sulting in the u	nderlying	cause give	en in Part I.			accouse s 2 🖔 N		e cause of death?
Vital Records,	. a cr	Completed							_	24a. Was a autops perform	V	4b. Were auto prior to cor death? 1 □ Yes	psy findings available inpletion of cause of 2 No
Vita	Physician: Th this certificate ral director, pag	Be C	25. Was case referred to medical examiner? 1X Yes 2 □ No	Hospital:	ð		Othe	00		Check only on			
Division of	ding After fune	tion: To	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	ER/Outpatier 28b. Time of Injury		28c. Injury Work	4 U Nurs	28	d. Describe ho		Other (Specif) ccurred	")
Divisi	A - 0 Q	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Spec	nome, farm, str ify)	reet, factor	y, office		28	f. Location (St. City or Town		lumber or Rura	l Route Number,
	To the Hoepital or within 24 hours afte To the Funeral Dis completely filled in	edicai (	29a. Certifier 1 Z Cartifying Ph (Check only one) 2 Medical Exam	ysician: To the best of my kn niner: On the basis of examin and manner stated.	owledge, deatl ation and/or in	h occurred vestigation	at the tim	ne, date and pinion, death	place, and occurred	d due to the ca at the time, da	ause(s) and ate and pla	d manner as st ace, and due to	ated. the cause(s)
	To the within 2 To the comple	¥	29b. Signature and tilte of certifier	in la	10		o. License 01364			25		igned (Month, ich 8, 20	
,	D		30. Name and address of person who James J. Welsh, M	completed cause of death (Ite .D. 845-B Quir	m 23a) (Type, nce Orc	Print) hard	Blvo	l. Gai	thers	burg,	Mary1	and 208	3 <b>7</b> 8
	Sta Registr		31. Date filed (Month, Day, Year) VMAR 1 3 2	32 Registrar's Sign	atoro	ade							

Registrar

27

2006

Please T	ype or	Print	in	Black	Indelib	e Ink.	Ensure	All	Copies	Are	Legible
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2000			1 - For StateMFND#7perFH2/27 RegistrarAmend#12VR2	State of Marylan			nt of Healt te of Dea			gieņe	6 07782
14	Physici		1. Decedent's Name (First, Middle, La Ahmed M.						2. Date of Dea	Day	Year 9:36 A M
8 , 5	/Medio		4a. Facility Name (If not institution, give		I	4b. City	, Town, or Locati	tion of Death	Februar	4c. County of	
196			Doctors Commu	nity Hospita	1	Lan	ham			Princ	e Georges
<b>*</b>	Funeral Director		210-01-0372	7. Age (In yrs. 2.2)		If Unde Months		nder 24 Hrs. urs Min.	8. Date of Birth (Month, Day 3 / 6 / 1	983	Birthplace (State or Foreign Country)     Sudan
	land		Usual Residence of Decedent  10a. State 10b. County		y, Town or Lo	cation					10d. Inside City Limits
	Mary In the	tor	Md Prince	Georges	anham	l					1 ☐ Yes 2X No
	th the	irec	10e. Street and Number			10f. Zi	p Code			10g. Citizen of W	hat Country?
	23a c	rai D	7549 Wilhelm	Dr.		20	706			Sudan	
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23e or 28e-f show many injury or other traumatic event, the Mudical Example and the modified at ODGE.	by Fune	11. Marital Status  1   Mever Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U. Armed Forces? 1 □ Yes 2 No If Yes, Give 7 2 6 7 1 Year or Dates 7 2 4 7		Vas Dece Yes, spe	edent of Hispanic ecify Cuban, Mex 2 1 No Spec		ecify Yes or No- Rican, etc.)		- American Indian, , White, etc. black
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121	within ane. then	mpi	Elementary/Secondary (0-12)	College (1-4or 5+)			use retired)				
d 2	Hygie Hygie ther	ပို င	17. Father's Name (First, Middle, Last	)	uner	ірто	-	lother's Name	(First, Middle,	none  Maiden Surname	)
/lan	uld be Mental wrked c	To B	Musa Moham	ed				Samir		lfaki	,
Maryland	id 2 sho lth and 27 is mu traum		19a. Informant's Name/Relationship (Abdelrahim Sali	Type, Print) h/brother_in	19b. Mailin	g Addres	s (Street and Nu.	amber or Rura	I Route Numbe	r, City or Town, S	State, Zip Code)
ē,	t Heal		zoa. Method of Disposition	200. F	lace of Dispos	sition (/va	ine oi	Te Ku	ate Liaii		City or Town, State
E O	Page III		1 Burial 2 Cremation 3 4 Donation 5 Other (Special	Hemoval from State	emetery, crem orge W		ington	2/2	4/06	Adelphi	, Md.
Baltimore,	partm porta y inju		21. Signature of Funeral Service Lice		_		nd Address of Fa	1			uary
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			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the death one cause on each line.	n. Do not ente	er the mo	de of dying, such	h as cardiac c	r respiratory ari	rest,	Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	. RESPIRM	ORY	FA	LURE				Onset and Death
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8760,	cate be execu physician and the burial-tra	dical	•	a METASTM	TC S	SAR	COMA	OF	THE	LUNG	
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Records,	w requir been si should I	Completed by							1 🗆 Y	es 2 No	3 Probably 4 DUnknown
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ion	ath. r: Aft	atio	1 Matural 5 ☐ Pending 2 ☐ Accident investigatio		Injury	м	Work? 1 ☐ Yes 2	2 □ No			
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	To the Hospital or Attending Phwithin 24 hours after death. To the Funeral Director: After the completely filled in by the funeral	Medical	29a. Certifier 1 Certifying Pl (Check only one) 2 Medical Example 1	nysician: To the best of my kno niner: On the basis of examinal and manner stated.	wledge, death tion and/or inv	occurred	at the time, date n, in my opinion,	e and place, a death occurr	and due to the o ed at the time, o	cause(s) and man date and place, a	ner as stated. nd due to the cause(s)
	To the within To the Compl	Me	29b. Signature and title of certifier	1		29	c. License numb	ber	- 2	29d. Date signed	(Month, Day, Year)
	2/		M. 4. X	for mo			D6155	52		Februar	4 23,2006
	V		30. Name and address of person who	completed cause of death (Item	23a) (Type, I	Print)				· · · · · · · · ·	1
	1071 1078 "A		Kevink Ertan 31. Date filed (Month, Day, Year)	MD 8/18 G	ood Luc	K Ko	ad Lar	nham M	1D 201	06	
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Consider Name   Teach Markon   Tea				1 - For State Registrar	State of Ma		d / Depa	artme	nt of H		and M	-		nn	6 (	77	83
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Physician (Modical Examiner)  Physic	20	Por Hite		1 X Burial 2 ☐ Cremation 3 ☐		CE	metery, crer	natory or	other place	9)		1			-		_ 3
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Physician (Needical Examiner)  Physician (Needical Examiner)	Ba	permi Depe Impo any i		21. Signature of Huneral Service Licens	1/2000	0.											20012
Physician (Modical Examiner)  The physic	П			23a, Part1, Enter the disease, or comp	lications that caused	the death								ıgıo	л, D		
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25. Was case referred to medical examiner?    1	<u>α</u>	that the by detac	P		ntributing to death b	ut not resu	lting in the u	nderlvina	cause give	n in Part I.		23e. Did t	obacco u	se cont	ribute to th	e cause of	death?
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25. Was case referred to medical examiner?    1	Re	he far e has	ш							· · · · · · · · · · · · · · · · · · ·		autos	osv	F	prior to con death?	npletion of a	cause of
Manner of Death   Salaturat	ta			25. Was case referred to medical						oe Place	of Doath				☐ Yes	2□ No	
1   2   2   2   2   2   2   2   2   2	<u> </u>	9 v =		examiner?	Hospital: 1 ☐ Inpatie	ent 2 🗆 E	ER/Outpatien	t 3 🗆 🗅	OA Othe					S XIOth	er (Snecifi	hoer	nico
The state of the s	9	g Ph ter thi			28a. Date of Inju	ry	28b. Time of		28c. Injury	at						7 HOSE	TCE
29a. Certifier (Check only one)  29b. Signature and title of certifier  29c. License number  29c. License number  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Joseph Kaplan, M.D. 6001 Muncastle Mill Road, Rockville, MD 20855	io	ath. or: Af	atio	2 Accident investigation		, oui,	inquiry	м			No						
29a. Certifier (Check only one)  29b. Signature and title of certifier  29c. License number  29c. License number  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Joseph Kaplan, M.D. 6001 Muncastle Mill Road, Rockville, MD 20855	Ĭ	ter de frecto	tHo	data_in_d	286. Place of Inj	ury - At ho	me, farm, str	eet, facto	ry, office		2				er or Rura	l Route Nun	nber,
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D35635 February 20, 2006  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Joseph Kaplan, M.D. 6001 Muncastle Mill Road, Rockville, MD 20855		Hosp 24 hole Fund letely fi	dlcai	(Check only 2 Medical Exam	iner: On the basis of	f examinat	wledge death ion and/or in	i creuma vestigatio	at the tin	ie, date an pinion, deal	d place, a th occurre	nd due to the ed at the time,	cause(s) date and	place,	and due to	aled. the cause(	s)
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Joseph Kaplan, M.D. 6001 Muncastle Mill Road, Rockville, MD 20855	}	24		1 ~ 1 Kr/		~	"		D356	35		1	Febru	ıary	20,	2006	
Joseph Kaplan, M.D. 6001 Muncastle Mill Road, Rockville, MD 20855  State Registrar  State Registrar  State Registrar  State Registrar  State Registrar		1		30. Name and address of person who c	ompleted cause of d	eath (Item	23а) (Туре,	Print)									
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3	. ₹.	F	1. Decedent's Name (First, Middle, Last)					2. Date of Dea		3. Time of Death
	Physici /Medic		ANNE ELIZABETH MUN					0.3	08 06	3:40 A.M.
4	Examin	er	4a. Facility Name (If not institution, give s	treet and number)		4b. City, Town, or	r Location of De	ath	4c. County of Dea	
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. ia	st birthday)	If Under 1 Year	OCK ( CU If Under 24 H		HILEGA h 9. Bir	thplace (State or Foreign
Æ	Director		279-24-7147	M 2134	85 Yrs.	Months Days	Hours M	in. 1 <sup>(M</sup> 88 <sup>th</sup> , 1 <sup>2</sup> 9	21 <sup>ear)</sup> MAR	YLAND
	and *	1	Usual Residence of Decedent  10a. State 10b. County	10c. City.	Town or Lo	cation				10d. Inside City Limits
	Maryl f eho	tor	MD ALLEGANY		OSTBUR					1 ∑ Yes 2 □ No
	or 28a	Director	10e. Street and Number		<del></del>	10f. Zip Code			10g. Citizen of What.C	ountry?
	ath wit	raiD	30 VICTORIA LANE			21532			U.S.	
99	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other then "naturel", or Ilems 23s or 28s-f show surnatic event, the Medical Examinar must be notified at	by Funerai	1 ☐ Never Married 2 ☐ Married	<ol> <li>Was Decedent Ever in U.S Armed Forces?</li> <li>1 ☐ Yes 2 XNo If Yes, Give</li> </ol>	11	Vas Decedent of H Yes, specify Cuba □ Yes 2 12 No	lispanic Origin? an, Mexican, Pu Specity:	(Specify Yes or No- erto Rican, etc.)	14. Race - Am Black, Whi Specify: WH	te, etc.
Ş	ture!	ed b	3 XWidowed 4 ☐ Divorced  15. Decedent's Educ	Year or Dates:	16a. Deced	ent's Usual Occup	ation		16b. Kind of Business	
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2	filed wit Hygien other th	Соп	8		ho	memaker			own home	
and	ould be fil Mental H tarked oth	Be	17. Father's Name (First, Middle, Last) NICHOLAS HOLTZ				18. Mother's N	lame (First, Middle, TRTCΔ	Maiden Sumame)	
Maryland 21215-0036	should ind Men	은	19a. Informant's Name/Relationship (Typ	pe, Print)	19b. Mailin	g Address (Street			r, City or Town, State,	Zip Code)
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altimore,	ges 1 and 2 should t of Health and Men if item 27 is marke or other treumatic		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Re	l ce	ace of Dispos metery, crem	sition (Name of natory or other plac	ce)	Date	20c. Location - City or	Town, State
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å å			23a. Part1. Enter the disease, or complic shock, or heart failure. List only on	e cause on each line.			ng, such as card	iac or respiratory ar	rest,	Approximate Intervat Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a conseque	TIVE	14=1	RT F	ALLURIE		5 day
174	Examiner			CORUN		MITE	ou D	(SIEAS)E	6	يرزداك والمراك
	D =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a conseque		111-11-	7 1	19/1		
V	and -trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conseque	once of:					
8760,	Attending Physician: The law requires that the death certificate be executed rideath.  sctor: After this certificate has been signed by the attending physicien and by the inneral director, page 2 should be detached for use as the burial-transit.	dical E		Due to (or as a conseque	erice or).					
687	tificate ig phy: as the	ledic								
Вох	death certifica attending pt if for use as ti	an/N	tF FEMALE: 23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregnan 1□Live birth 2□Fetal		Ectopic pregnancy	,		23d. Date of de Month	livery Day Year
o.	he dea	Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□ Pregnant at time of dea 9□ Unknown	ath 5□	Other (specify)			Worth	ouy roar
۳.	res that the designed by the a	by Ph	Part II. Other significant conditions con	tributing to death but not resul	lting in the ur	nderlying cause giv	en in Part I.	23e. Did to	bacco use contribute t	o the cause of death?
rds	w requires been sign should be	ed b	PNEnmon	MA				1 U Y	′es 2□No 3□P	robably Unknown
ecc	e law re has be je 2 sho	Completed						24a. Was autop	an 24b. Were a prior to	utopsy findings available completion of cause of
<u>س</u>	Physician: The la rthis certificate has ral director, page 2	Cou							med? death? 2 → No 1 ☐ Yes	s 2□No
₹	sician	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	ospital:	R/Outpatien	Oth Oth	00	Death (Check only o		4.1
ō	g Phy er this eral d	n: To	27. Manner of Death	7	28b. Time of	C 3 DOX	4 14012111	7	ence 6 Other (Speciow intury occurred	ecity)
ion	uttending death. ctor: Aft y the fun	atio	1 Natural 5 Pending investigation	(Worth, Day 1 ear)	Injury		Yes 2 □No			
Division of Vital Records,	after de l'Direct	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At hor building, etc. (Specify)	me, farm, stre )	eet, factory, office		28f. Location (S City or Ton	Street and Number or A vn. State)	ural Route Number.
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical C	29a. Certifier (Check only one)  Certifying Physical Examination	ician: To the best of my know er: On the basis of examinati and manner stated.	vledge, death on and/or inv	occurred at the tir restigation, in my o	ne, date and pla pinion, death or	ace, and due to the courred at the time,	cause(s) and manner a date and place, and du	s stated. e to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	`		29c. Licens			∠9d. Date signed (Mon	
			He	Ym		026	5907	/	MARCH 8	2006
	6		30. Name and address of person who co	dhu 925	Bish	Print) OP WAS	sh Roa	d, Cumb	perlandin	2006
1000	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Signati	ure Ange	N. P				
10	, registi	पा	MAR 1 4 2006		100	7.5				

			For State Registrar	State of Mary		artment of H		- 1	giene	07785
	Physicia		1. Decedent's Name (First, Middle, L	ast) ZHAM				2. Date of Dea Month	Day Year	1 4 .4
	/Medic Examin		4a. Facility Name (If not institution, gr			4b. City, Town, or			4c. County of De	
			5. Social Security Number 6.	Sex 7. Age (In	- I sa bisabula	ELKTO.	If Under 24 Hrs	- 10 Date - ( Dist	CEGI	
	Funeral Director		213-20-7582 Usual Residence of Decedent	1 M 2 XF 80	yrs. last birthday, Yrs.	Months Days	Hours Min		y, Year) 9. 8 1925 Ma	rthplace (State or Foreign Country) ryland
	yland how		10a. State 10b. County	100	. City, Town or L	ocation				10d. Inside City Limits
:	oeain with the Maryland ms 23a or 28a-f show [must be notified at	Director	MD Cecil		Northea	ast				1 ☐ Yes 2 No
	or 28	Dire	10e. Street and Number			10f. Zip Code			10g. Citizen of What C	Country?
-	ns 23	erai	529 Trinity Chu:	rch Road  12. Was Decedent Ever	in IIS 13	21901 Was Decedent of H		Spacify Vas or No-	U.S.A.	perican Indian
	within 72 hours after beain with the Marylan then "haturel", or Items 23a or 28a-f show then "Medical Examiner must be notified at	by Funeral	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces?  1  Yes 2 No If Yes, Give Year or Dates:	110.3.	If Yes, specify Cuba  1 ☐ Yes 2X No	Specify:	to Rican, etc.)	Black, Wh	
3-003p	atura eal E		15. Decedent's I	Education	16a. Dece	edent's Usual Occupa	ation	-	16b. Kind of Busines	
212	within / ene. than "n ne Medi	Completed	(Specify only highest g Elementary/Secondary (0-12)	rade completed)  College (1-4or 5+)	(Give	e kind of work done o DO NOT use retired	during most of wo d)	rking		•
A .			12	0	Secre	etary			Civil Ser	vice
	e d fa b	o Be	17. Father's Name (First, Middle, Las Roscoe Kilby	<i>i)</i>					Maiden Sumame)	
5	z should be and Menta is markad aumatic ev	ĭ	19a. Informant's Name/Relationship	(Type, Print)	19b. Mail	ing Address (Street a		Mae Blev	VIIIS er, City or Town, State,	Zip Code)
=	allth a 27 is		Drinda Jones (Da	aughter)		Trinity (			theast, MD	21901
<u>ව</u> .	es la of Hez of Hez fitem	L Ed	20a. Method of Disposition  →1 □ Burial 2 □ Cremation 3	Demoval from State	Ob. Place of Disponentery, cre	osition (Name of ematory or other place	ce)	Date	20c. Location - City of	r Town, State
	nit. Pages artment of ortant: If it injury or o		`4 □Donation 5 □Other (Spec	ify) H		Mem. Gdns.		4/06	Aberdeen,	MD
ga	permit. Pages Department of Important: If i any injury or one		21. Signature of Juneral Service Lice	ensee	2	2. Name and Addre Tarring—( Aberdeen,	ss of Facility Cargo Ful MD 21	neral Hor	me, P.A.	
F	hysician /Medical		23a. Part1. Enter the disease, or co shock, or heart failure. List onl Immediate Cause (Final disease or condition resulting in death)	y one cause on each line.	6	iter the mode of dyin	g, such as cardia	c or respiratory ar	rest,	Approximate Interval Between Onset and Death  LICEK
ρυ, Λ	cate be executed by social and by sician and sthe burial-transit	dical Examiner	Sequentially list conditions, any, leading to in mediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a col	O.5.5-	troctur	- Polm 	) Pu	segn	Years
O. BOX	requires that the death certificate een signed by the attending phys hould be detached for use as the	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 \( \subseteq \text{vs} \) 2 \( \subseteq \text{No} \) 9 \( \subseteq \text{Unknown} \)	23c. If yes, outcome of pr 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death 3	□Ectopic pregnancy □ Other (specify)	′		23d. Date of d Month	elivery Day Year
ds, r	w requires that been signed by should be deta		Part II. Other significant conditions  Right Discourse D	contributing to death but no	t resulting in the t	underlying cause give	en in Part I.		obacco use contribute	to the cause of death
ပ္	≥ Ω Ø	Completed by	Lypo thyroidism					24a. Was autop perfor	an 24b. Were a prior to death?	autopsy findings available completion of cause of
<u>.</u>		a	25. Was case referred to medical				26 Place of De	1 ☐ Yes ath (Check only o	2 No 1 Ye	s 2 No
5	hysician: this certific al director,	To B	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 Inpatient	2 ER/Outpatie	nt 3 DOA Oth			dence 6 Other (Sp	ecify)
lo no	nding Ph tth. :: After th e funeral		27. Manner eath 1 atural 5 Pending 2 Accident investigati	28a. Date of Injury (Month, Day Yea	28b. Time of Injury	Worl		7	now injury occurred	
DIVISION	Hospital or Attending Physician: 4 hours stater death. Funeral Director: After this certificitied in by the funeral director,	Certification:	3 Suicide 6 Could not determine	be 28e. Place of Injury - building, etc. (S	At home, farm, si	treet, factory, office		28f. Location (S City or Tow	Street and Number or F vn, State)	Rural Route Number,
:	0 CV 00 D	edical (	29a. Certifier 1 Certifying F (Check only one) 1 Medical Ext	Physician: To the best of my aminer: On the basis of exa and manner stated.	knowledge, dea mination and/or in	th occurred at the tin	ne, date and plac pinion, death occ	e, and due to the ourred at the time, o	cause(s) and manner a date and place, and du	as stated. se to the cause(s)
	To th within To th compl	Me	29b. Signature and title of certifier	0001		29c. License	e number		29d. Date signed (Mor	nth, Day, Year)
			· Well	ful }	m	Doc	6275	9	Mach 8	2006
	Q		30. Name and address of person wh	o completed cause of death	_	Print)				
	() Sta	to	31. Date filed (Month, Day, Year)	2. Registrar's	ST Signature	RIKTH	m1)			
	Registr		MAR 1 4 20	06	A Goo	de la				

Registrar

DHMH 17 Rev 1/2001

State

market

111 Penn Street

Baltimore, Maryland 21201

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

22. Registrar's Signature

HOGAV

4 2006

31. Date filed (Month, Day, Year)

		1	State of Maryland / Department of Health and  1- State Registrar  Certificate of Death		giene	07787			
	A		Decedent's Name (First, Middle, Last)	2. Date of Dea	ith	3. Time of Death			
	Physicia		Clara Stewart Mason	Februa	Day Year 1ry 21, 2006	9:31 P M			
	/Medic Examin		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Dea		4c. County of Deat				
	Lxamiii	4	Shady Grove Adventist Hospital Rockville		Montgo	merv			
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hr		h 9. Birtl	nplace (State or Foreign untry)			
	Director		156-14-9263 1 N M T 101 Yrs. Months Days Hours Mir	July 17		* '			
	2		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits			
	aryia shov	_	Tour state			1 ☐ Yes 2x ☐ No			
	8a-f	Director	Maryland Montgomery Silver Spring		10g. Citizen of What Co				
	with th	급	10e. Street and Number 10f. Zip Code			Dritty :			
	ath v	Funeral	3376 Cheswick Court 20906  11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin?	(Specify Yes or No-	U.S.A.	rican Indian.			
	er de Itam Der n	n.	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 Never Married 2 Married  1 Yes 2 Armed Forces?	erto Rican, etc.)	Black, White				
36	I', or	by F	If Yes, Give 1 Yes 2 No Specify:  3 X Widowed 4 Divorced Year or Dates:		Specify: Wh	ite			
21215-0036	filed within 72 hours after death with the Maryland Hydiene. ther than "natural", or Itama 23a or 28a-f show int. Itta Medical Examiner must be notified at	ed	15. Decedent's Education 16a. Decedent's Usual Occupation	and disco	16b. Kind of Business/	Industry			
15	nin 73	ple	(Specify only highest grade completed) (Give kind of work done during most of w life. DO NOT use retired)  Elementary/Secondary (0-12) College (1-4or 5+)	vorking	Montgomery	•			
212	d with	Completed	4+ School Teacher		School Sys	stem			
Þ	be file ital Hyg od othe avent.	Be	17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Last)	lame (First, Middle,					
<u>a</u>	ould by Menta	nson							
Maryland	2 sho and h ls ma	ဥ	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Information 19b. Mailing Add	Rural Route Numbe	r, City or Town, State, 2	Zip Code)			
	and 2 ealth n 27		Self - by pre arrangement 3376 Cheswick Court,						
Baltimore,	一直電車		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State	Date	20c. Location - City or	Town, State			
<u>Ĕ</u>	Pages ment of ant: If ft ury or o		4 □ Docation 5 □ Other (Specify) Metropolitan Crematoriun	2/26/06	Alexandria,	Virginia			
alt	permit. Departr Imports any inju		21. Signalure of Fineral Service Licensee  22. Name and Address of Facility Molesworth—William	ms P.A.	Funeral Hom	ie.			
<u> </u>	20119		rever 2 . Nouver 26401 Ridge Road.	Damascu	s. Maryland	20872			
	Physician /Medical Examiner		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardishock, or heart failure. List only one cause on each line.	iac or respiratory ar	rest,	Approximate Interval Between Onset and Death			
			Immediate Cause (Final disease or condition a COLATE AUSTRULTMAN (AUSTRULTMAN)						
			Due to (or as a consequence of):		V	MIMICS			
187	Lxammer	_	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):						
	si ad	lne	if any, leading to immediate Due to (or as a consequence or).  cause. Enter Underlying  Cause (Disease or injury						
	be execut icien and burial-tran	Examiner	that initiated events c.  resulting in death) Last Due to (or as a consequence ol):						
760,		calE							
687	phys phys s the	_	Q						
Box (	death certifica e attending ph id for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant		23d. Date of de	livery			
B	atter d for u	clar	In the past 12 months?  1   Live birth 2   Fetal death 3   Ectopic pregnancy 4   Pregnant at time of death 5   Other (specify)		Month	Day Year			
P.O.	the cy the achec	hys	9 ☐ Unknown						
<u>.</u>	law requires that the as been signed by th 2 should be detache	by P		23e. Did to	obacco use contribute to	the cause of death?			
Vital Records,	quires in sign	pa pa	Toronam artery aisease	1 🗆 1	Yes 2 No 3 P	obably 4 Unknown			
ဝ	s been si should	Completed		24a. Was		topsy lindings available completion of cause of			
Re	9 5 9	E		perfo	ormed? death? 22 No 1 ☐ Yes				
tal	ician: Th certificate rector, pag	a)	25. Was case referred to medical 26. Place of D	Death Check only o					
	tending Phyeician: leath. tor: After this certific the funeral director.	0.0	examiner? 1   Yes 2   No   Hospital: 1   Inpatient 2   ER/Outpatient   DOA   Cther: 4   Nursing	g Home 5 ☐ Resid	dence 6 □Other (Spe	cify)			
10		n: T							
jo		atlo	1 (Notice) 1 (Notice)						
Division of	er de recto by th	Certification;	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (S City or Tox	Street and Number or R wn, State)	ural Route Number,			
	rs after all Dir	Cer							
	To the Hospital or Atter within 24 hours after de To the Funeral Directo completely filled in by th	Medical	29a. Certifier (Check only (Ch	ace, and due to the courred at the time,	cause(s) and manner as date and place, and du	s stated. e to the cause(s)			
	To the h within 2- To the I	Med	one) and manner stated.  29b Signature and title of celetitier 29c. License number		29d. Date signed (Moni	th Dev Year)			
	with To	-	29b. Signature and Title of celtifier 29c. License number	7	O   Sales Signed (Month	21 3 -			
,			DU5 300	7	emany	2006			
j	(0)		30. Name and address of person w o colleted cause of death (Item 23a) (Type, Print)	rvland 2	0850				
			9901 Medical Center Drive, Rockville, Mar 31. Date liled (Month, Day, Year) FFR 2.7 006	Lytanu Z	3030				
	St: Regist	ate	FEB 2 7 2006 Shaw 15 April						

	State of Maryland / Department of Health and Mental Hygiene  Certificate of Death  Reg. No.									07788	
			1. Decedent's Name (First, Middle, L	ast)				2. Date of	Death		3. Time of Death
	Physici /Medio		HENRY WILLIAM MORIN					FEBRU	ARY 20,	Year 2006	10:00 PM
	Examir		4a. Facility Name (If not institution, g		r)	4b. City, Town, o	r Location of			ty of Death	10:00 1
			SPA CREEK NURS	ING HOME		ANNAPOL	ES		ANNE	ARUND	EL
	Funeral			Sex 7. A	Age (In yrs. last birthda)	If Under 1 Year	If Under 24		Birth	9. Birth	place (State or Foreign
	Director		369-14-4137	1 <b>X</b> M 2□F	86 Yrs.	Months Days	Hours		Day, Year) 18,1920	MI.	ntry)
	pr ,		Usual Residence of Decedent								
	anyla shov	_	10a. State 10b. County		10c. City, Town or I	coation					10d. Inside City Limits
	Ba-f	cto	MD ANNE A	RUNDEL	ANNAPOL	LS.					1 X Yes 2 □ No
	or 2	Director	10e. Street and Number			10f. Zip Code			10g. Citizen o	f What Cou	ntry?
	23a	rai	2678 CUNNINGHAM I	HOLE ROAD		214	401		UNITED	STAT	ES
	ep a	by Funeral	11. Marital Status	12. Was Deceder Armed Forces	5?	Was Decedent of H If Yes, specify Cubi	lispanic Originan, Mexican, I	n? (Specify Yes or Puerto Rican, etc.)		ace - Americack, White,	
36	or it	Y.	1 Never Married 2 Married	1 XYes 2 If Yes, Give	]No	1 ☐ Yes 2 🛣 No	Specify:	,	Spec		0.0.
215-0036	within 72 hours after death with the Maryland ene. than "naturel", or items 23a or 28a-f show ha Madical Examinar must be notified at	Completed b	3 ☐ Widowed 4 ☐ Divorced	Year or Dates					0,000	WHI	TE
5	"nat		15. Decedent's l (Specify only highest g	Education rade completed)	(Giv	edent's Usual Occup e kind of work done	during most o	of working	16b. Kind of	Business/In	dustry
12	withii ane. than	m d	Elementary/Secondary (0-12)	College (1-4o	r 5+)	DO NOT use retire					
121	filed withii Hygiene. other than ent, the M		17. Father's Name (First, Middle, Las	5+	INSU	RANCE SPEC		s Name (First, Midd	GOVERN		
ano	ould be i Mental I marked o	To Be	WILLIAM J. MORIN	.,,						urie)	
Maryland	s 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hygiene. Item 27 is marked other than "naturel", or items 23a or 28a-f show other traumatic avent, the Madical Examiner must be notified at		19a. Informant's Name/Relationship	(Type Print)	10b Mai	ing Address (Street		TIE GITZ			0.11
Ma	d 2 sho th and 7 Is my traum					ing Address (Street			noer, city or row	n, State, Zip	Code)
	os 1 and 2 of Health item 27 I		ISOBEL MORIN (WI) 20a. Method of Disposition	EE)	20b. Place of Disp	S CUNNINGE osition (Name of	IAM HOI	LE ROAD .	20c. Location		
Baltimore,	ages If it		1 ☐ Burial 2 X Cremation 3		• CHESAPEA	KE CREMAT	CON _			•	
ij	rtmer rtant njury		'4 □ Donation 5 □ Other (Spec	A	CE	NTER	2/	21/2006	STEVE	ISVILI	E, MD
Bal	permit. Pages: Department of I- Important: If ite any injury or ot		21. Signature of Funeral Service Lice	Nyc	Jell :	2. Name and Addre ADAMS OF A B14 BESTGA	ANNAPOI ATE ROA	D ANNAPO	LIS, MD	REMAT 21401	ION CARE
	Physician /Medical		23a. Part1. Enter the disease, or con shock, or heart failure. List onl	mplications that cause y one cause on each	ed the death. Do not en line.	nter the mode of dyin	ng, such as ca	ardiac or respiratory	arrest,		Approximate Interval Between
			Immediate Cause (Final disease or condition	. (	arehowaid	er art	eriord	lenvi's			Onset and Death
			resulting in death)	Due to (or a	s a consequence of):						
	Examiner		Sequentially list conditions,	b							
	D #	Examiner	if any, leading to immediate cause. Enter Underlying	Due to (or a	is a consequence of):						
	cate be executed physician and s the burial-transit	am	Cause (Disease or injury that initiated events resulting in death) Last	C							
30,	sian a	Ē	Tooking in coally 2200	Due to (or a	s a consequence of):						
68760,	cate be execu physician and the burial-tra	dical	•	d							
_			IF FEMALE:								
Вох	ie death certifii the attending p hed for use as	lan/	23b. Was decedent pregnant in the past 12 months?  1 □ Yes 2 □ No  9 □ Unknown  23c. If yes, outcome of pregnancy  1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy  4 □ Pregnant at time of death 5 □ Other (specify) □ □ Unknown						23d. Date of delivery		ory Day Year
		Physician/M						-	Month Day Year		
P.0	that the de ed by the detached	Phy									
S,	The law requires ate has been sign page 2 should be	To Be Completed by	Part ii. Sales significant conditions contributing to death out not resulting in the underlying cause given in Part i.						23e. Did tobacco use contribute to the cause of death?		
Records,								11	Yes 2 Ho	3 ∐ Prob	ably 4 Unknown
ec								24a. W	as an 24b.	Were auto	psy findings available appletion of cause of
- H									rformed?	death? 1 ☐ Yes	
Vital			25. Was case reterred to medical examiner?				26. Place of	f Death (Check onl			
of V	Physic this ce al dire		1 ☐ Yes 2 ☐ No	Hospital: 1 Inpa	tient 2 ER/Outpatie	nt 3 DOA Oth	er: 4 Nurs	ing Home 5 □ Re	sidence 6 🗆 Ot	her (Specify	()
П	ding Physician:  n. After this certific funeral director,		27. Manner of Death 1 ☐Natural 5 ☐ Pending	28a. Date of In (Month, D	jury 28b. Time lay Year) Injury	of 28c, Injur Wor	y at k?	28d. Describ	e how injury occu	rred	
<u>Si</u>	Attending or death. ector: After by the fune	atic	2 ☐ Accident investigation	on			Yes 2 □ No				
Division	I or Attendi after death. Director: A I in by the fu	Certification:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	286. Place of I	njury - At home, farm, s etc. (Specify)	reet, factory, office		28f. Location	(Street and Num own, State)	ber or Rura	l Route Number,
0	rs aft al Di	Cer									
	To the Hospital or within 24 hours after To the Funeral Director completely filled in D	Medical	29a. Certifier 1 Certifying P (Check only one) 2 Medical Exe	hysicien: To the bes miner: On the basis and manner:	it of my knowledge, dea of examination and/or i stated.	th occurred at the tin nvestigation, in my o	ne, date and p pinion, death	place, and due to the control occurred at the time	ne cause(s) and m e, date and place	anner as st , and due to	ated. the cause(s)
	withii To the		29b. Signature and title of certifier			29c. Licens		21	29d. Date sign	6 -	
	ju		> 1) 4/w	Sur			0 390	36	2/2/	17715	6
	10		30. Name and address of person who	completed cause of	death (Item 23a) (Type	, Print)		c 0 1			
			Gast Sir	use of	1 1 - 1 1	arub Di	in (	Lester.	WW 7	1619	
	Sta	te	31. Date filed (Month, Day, Year)	32. Regi	trar's Signature	1					
	Registr	ar	FFR 2 3	2006	ague H.	Brooks)					

State of Maryland / Department of Health and Mental Hygiene Reg. No. Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) <sup>2</sup>25, 2006 February **Physician** Amal Aref Noueihed 4:50A. /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Anne Arundel Medical Center Annapolis Anne Arundel June12, 1953 If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours 1 ☐ M 2 🗙 F 52 Yrs. none Lebanon Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ir than "natural", or Items 23s or 28s-f show the Madical Examinar must be notified at Crofton 1 ☐ Yes 2 🕅 No Maryland Anne Arundel Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2452 Chelmsford Drive 21114 Lebanon e filed within 72 hours after death val Hygiene.
Other than "natural", or Items 23s. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ∑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No White Specify ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Homemaker permit. Pages 1 and 2 should be liled w
Department of Health and Mental Hygier
Important: if Item 27 is marked other ti
any injury or other traumatic event. Ins own home 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Noueihed Aref Salma Modad 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Hafez Noueihed 2452 Chelmsford Drive Crofton, Maryland 21114 -husband 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Noueihed Family Cemetery 3/1/2006 Raselmaten, Lebanon 4 ☐ Donation 5 ☐ Other (Specify) Donald V. Borgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland 20705 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death tmmediate Cause (Final Breast Cancer **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Dua to (or as a consequence of). Examine attending physicien and for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No
9 Unknown 3 Ectopic pregnancy Month Day 5 Other (specify) been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate has birector, page 2 s 1 🗌 Yes 2 2 No : After this certifice a funeral director, p Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day Year) Certification: To 1 Yes 2 No 2 ER/Outpatient 3 DOA 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident Injury 5 Pending within 24 hours after death.

To the Funeral Director: Af death. 1 Tyes 2 No investigation 6 Could not be determined 3 🗌 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 900 Bestgate SPIONICK, ML 31. Date filed (Month, Day, Year) 32. Registrar's Signature State FEB 2006 Registrar

DHMH 17 Rev 1/2001

DHMH 17 Rev 1/2001

			State of Manyland / Dor	partment of Health and M	•	-	
			1- State of Maryland / Dep State of Maryland / Dep State of Maryland / Dep Registra MEND#10a, b, cperFH2/28/06, BMW, McCo Ce			006 0	17791
	Physici	20	1. Decedent's Name (First, Middle, Last)		2. Date of Death Month		3. Time of Death
	Physicia /Medic	al	HOWARD PLAUT	4b. City, Town, or Location of Death	02	4c. County of Death	0945 AM
	Examin	er	4a. Facility Name (If not institution, give street and number)  SUBURBAN HOSPITAL	BETHESDA		MONTO-OME	CPU
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs, last birthda	The second secon	8. Date of Birth (Month, Day, Y		ce (State or Foreign
	Director		213-01-7346 1 1 2 F 9 6 Yrs. Usual Residence of Decedent		04-22-	09 Germa	iny
	yland		10a. State DC 10b. County None 10c. City, Town or	Location Washington		10d	I. Inside City Limits
	8a-f s	ctor	MONTCOMERY ROCKVILL	16	1		¥ØYes 2□No
	a within 72 hours after deeth with the Maryland Jione. I than "natural", or Iteme 23a or 28a-f show The Madical Examinat must be neitlied at	Funeral Director	10e. Street and Number 1412 Floral Street, NW	10f. Zip Code 20012		n Citizen of What Country Inited State	
	deeth	nera	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	B. Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - American Black, White, etc	
36	s after	by Fu	1 Never Married 2 Married 1 Tyes 2 No	1 ☐ Yes 2 ☐ No Specify:		Specify: whit	
21215-0036	2 hour		15. Decedent's Education 16a. Dec	cedent's Usual Occupation	16	b. Kind of Business/Indus	
215	within 7. ene. than "n	Completed	Flomentary/Secondary (0.12) College (1.40r.5+)	ve kind of work done during most of worki . DO NOT use retired) Senior Attorney		Internal Rev	renue
421	be filed w tal Hygier d other th		17. Father's Name (First, Middle, Last)		(First, Middle, Ma	Service	
lan	should be and Mental marked o	To Be	Max Plaut	Marian	ne Runshe	eim	
Maryland	permit. Pages 1 and 2 should be Department of Health and Mental Important: if Item 27 is marked any injury or other traumatic events.		19a. Informant's Name/Relationship (Type, Print) 19b. Ma	iling Address (Street and Number or Rura			ode)
	1 end Health em 27 ther tr		20a Method of Disposition 20b. Place of Dis	Heatherton Lane,	7	MD 20854 ic. Location - City or Town	n. State
TOL	ages ent of ht: # It		1  ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, ca	echaim Cemetery 02/	- 1	Israel	
Baltimore,	Departm Departm Importai any injui		21. Signature of Fune al Service Licenses	22. Name and Address of Facility			
	90 E E 9			Forchinsky Hebrew F 254 Carroll St., NW			0012 pproximate
			23a. Parts Safe the disease, or complications that caused the death. Do not eshock, or heart failure. List only one cause on each line.  Immediate Cause (Final		1	l Ir	nterval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)  a	preumo	1111		
Н	Examiner		Sequentially list conditions, b.				
	pet nslt	Examiner	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury				
o,	te be executed ysicien end ie burial-translt		that initiated events resulting in death) Last C				
8760	ate be hysicie the bu	lical	d				
89 X	death certificate be ettending physicid for use es the b	Physician/Medi	IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of delivery	
Box	death e etten d for u	ician	in the past 12 months?  1 Ves 2 No.  1 Ves 2 No.  1 Ves 2 No.	B Ectopic pregnancy Dother (specify)		,	ay Year
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of Vital Records,	sign d be	ρ	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.		cco use contribute to the	1/
eco	e law requ hes been je 2 shouli	Completed			24a. Was an autopsy	24b. Were autops	y findings available pletion of cause of
a! H	(D) CT		OF Was seen referred to modified			d? death? No 1 ☐ Yes 2	□ No
Z:	8	To Be	25. Was case referred to medical examiner?  1  Yes 2 No  Hospital: 1 Impatient 2 ER/Outpat	Other	me 5 Resident	ce 6 Other (Specify)	
n o	ding Ph th. After th funeral		27. Manner of Death 28a. Date of Injury 28b. Time (Month, Day Year) 1 Natural 5 ☐ Pending (Month, Day Year) 28b. Time Injury	of 28c, Injury at Work?	28d. Describe how		
Division	or Attending ther death. Director: After in by the fune	icati	2 Accident investigation 3 Suicide 6 Could not be	M 1 Yes 2 No	28f Location (Stre	et and Number or Rural F	Soute Number
Ď	al or A safter il Direct	Certification:	4 Homicide determined building, etc. (Specify)	stroot, taskery, office	City or Town,		
	To the Hospital or Atlandi within 24 hours after death To the Funerel Director: A completely filled in by the fu	edical (	29a. Certifier (Check only one) 1 ☑ Certifying Physician: To the best of my knowledge, de 2 ☐ Medical Examiner: On the basis of examination and/or and manner stated.	ath occurred at the time, date and place, investigation, in my opinion, death occurr	and due to the cau ed at the time, date	se(s) and manner as state and place, and due to the	ed. ne cause(s)
		Me	29b. Signature and time of certifier	29c. License number	290	Date signed (Month, Da	ay, Year)
	1.2+1		30. Name and address of person who completed cause of death (Item 23a) (Typ	1	12010	4	
	Sta	ate.	31. Date filed (Month, Day, Year) 32-Registrar's Signature	8600 Old Georgetow	m Road, 1	Bethesda, MI	20814
	Registi		FEB 2 8 2006	MARC	-		

HOWARD PLANT 3/25/06 0945 AM

JOHN A. PICKETT 06-01421 Amend Please Type or Print in Black Indelible Ink., Ensure All Copies Are Legible. unend item#1,23-b,27,28a-f,pen/le,g853,3/22/06 TT State of Maryland Department of Health and Mental Hygiene **RKD** For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Dav Physician Year John Allen Pickett, Jr. FEBRUARY 25, 2006 2:55P/Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ALLEGANY CUMBERLAND SACRED HEART HOSPITAL | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | 9. Birthplace (State Months Days Hours Min. | March 14, 1985 | Mary Land 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 10M 20F 20 215-13-1781 Yrs. Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show rthan "natural", or itsme 23a or 28a-f sho the McGical Examiner must be notified at 1 Fes 2 No Directo Maryland Dorchester Cambridge 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 605 Maryland Avenue **USA** 21613 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No þ Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Student College n and Mental Hygie 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be John Allen Pickett, Sr. Vickie Lynn McCabe 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 a Department of Health ar Importent: If item 27 is sny injury or other trau once. John Allen Pickett, Sr./Father 605 Maryland Ave., Cambridge, MD 21613 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) DorchesterMemorialPark 03/03/2006 Cambridge, MD 21 Agnature of Funeral Service Licensee Curran-Bromwell Funeral Home, 308 High St., Cambridge, MD 21613 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Asphyxia /Medical Due to (or as a consequence of): Examiner Aspiration of gastric contents while intoxicated Secuentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine Hospitel or Attending Physician: The law requires that the death certificate be executed ng physician and as the burial-transit resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Dav Year 4□Pregnant at time of death 5 Other (specify) the 9 Unknown 9 Unknown signed by d be detacl 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown been s 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

Notice 2□ No certificate has t irector, page 2 s autopsy performed? 1 Yes 2 No director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ €R/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) ۵ 1 XYes 2 No this After the 28b. Time of Injury 28a. Date of Injury (Month, Day Year) 27 Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural
2 X Accident 5 Pending investigation 1 ☐ Yes 2 🛣 No death. Subject aspirated on gastric contents Fnd 2/25/2006 unk filled in by the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Ptace of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 T Homicide unk within 24 hours a
To the Funerel C
completely filled i 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only one) To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) FEBRUARY 26, 2006 O.C.M.E.

State Registrar WUCE

treneme 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Gton

JURON

M 32. Registrar's Signature FEB 28 LUUU

111 PENN STREET BALTIMORE MARYLAND 21201

			For State	State of Maryla	ind / Depa			Mental Hy	giene 0 0 6	07793
			1 - State Registra/MFND#10e; 200001 1. Decedent's Name (First, Middle, Last)	EH3/1/06,EMW,M	bCo Cei	rtificate of L	<i>Death</i>	2. Date of De	Reg. No.	3. Time of Death
	Physici		MAX	PILTC +	+			Month Februa	Day Ye	ar
	/Medic Examin		4a. Fecility Name (If not institution, give s	treet and number)		4b. City, Town, or			4c. County of D	Death
			Suburban Hospital  5. Social Security Number 6. Sex	7 Ann (In in	a lasa kindada d	Bethesda	If Under 24 Hrs	1 0 D-1(D	Montgome	- J
	Funeral Director			M 2□F 7. Age (111 yr	s. last birthday) 5 Yrs.	Months Days	Hours Min	. (Month, Da	ny, Year) 0, 1920 Ne	Birthplace (State or Foreign Country)
	pu k		Usual Residence of Decedent  10a. State 10b. County		City, Town or Lo	cation				10d. Inside City Limits
	Maryla 1 • ho	ō	New York New York		oklyn	OBTOT				1 X Yes 2 No
	n the		10e. Street and Number 2113	DIC	JORTAN	10f. Zip Code			10g. Citizen of What	t Country?
	ath wit		·	4E		11229			United St	ates
	Reme Reme	Funeral	11. Marital Status 1  1 □ Never Married 2 □ Married	2. Was Decedent Ever in Armed Forces?	U.S. 13.	Was Decedent of Hi If Yes, specify Cuba	ispanic Origin? (S n, Mexican, Puer	Specify Yes or No rto Rican, etc.)	14. Race - A Black, W	American Indian, Vhite, etc.
036	72 hours after death with the Maryland 'natural', or Iteme 23e or 28e-f ehow dicel Exacilizar must be notified at	by	3 XWidowed 4 □ Divorced	1 ∰Yes 2 No If Yes, Give Year or Dates: Unkr	nown	1□Yes 2XINo	Specify:		Specify:	White
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М 2	e filed Il Hyg other	Be C	17. Father's Name (First, Middle, Last)		110	illo i c	18. Mother's Na	me (First, Middle	, Maiden Sumame)	
ylar	should be ind Mental marked c	To	Louis Piltch				Rose Wa			
Maryland 21215-0036	d 2 sh th and 7 ie m treum		19a. Informant's Name/Relationship (Type			ng Address <i>(Str</i> eet a William H			er, City or Town, Stat	e, Zip Code)
	as 1 and 2 should bot Health and Ment Iltem 27 is marked r other treumatic		Andrea Ansell, Gra: 20a. Method of Disposition		Charles and the second	william is sition (Name of matory or other place		The second second second second	20c. Location - City	or Town, State
Ē	Pages nent of land; if its	0.	1 ☑ Burial 2 ☐ Cremation 3 ☑ Re 4 ☐ Donation 5 ☐ Other (Specify)	mioval moin state	th Mose		2006	-	Pinelawn,	New York
Baltimore,	permit. Pages Department of timportant; if Ite ony injury or or		21. Signature of Funeral Service License	* #	22	. Name and Addres	s of Facility Riversid	e Chapel	s yn, NY 11	
			23a. Part 1 Enter the disease, or complic	ations that caused the de						Approximate
	Physician		shock, or heart failure. List only on Immediate Cause (Final disease or condition	a cause on each line.	lin C	BABUTK	mia			Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a cons	equence of):	Erryth	,			
	Lammer	- a	Sequentially list conditions, if any, leading to immediate	Due to (or as a cons	equence of):	scular	aiseo	se		
	uted id ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events							
90,	cate be executed physicien and the burial-transit		resulting in death) Last	Due to (or as a const	equence of):					
8760,	The law requires that the death certificate be executed he has been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	Physician/Medical	d.							
Box 6	eath certific attending p	n/Me	IF FEMALE: 23b. Was decedent pregnant	c. If yes, outcome of preg		3=			23d. Date of	delivery
	the atte	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 2 ☐ Fe 4 ☐ Pregnant at time of 9 ☐ Unknown		]Ectopic pregnancy ] Other (specify)			Month	Day Year
P.0	that the de ted by the detached		9 ☐ Unknown  Part II. Other significant conditions confi		esulting in the w	nderlying cause give	an in Part I.	23e. Did t	obacco use contribute	e to the cause of death?
of Vital Records,	uires l n signe	d by	·			,		10		Probably 4 Unknown
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sion	Attending F r death. ector: After by the funer	atlo	1 Section 1 Section 2 Accident 5 Pending investigation	(Month, Day Year)	Injury		res 2 □ No			
Division	f or Attend aftar death Director:	ertification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At building, etc. (Spe		eet, factory, office		28f. Location ( City or Tox		Rural Route Number,
7	To the Hospitel or Attent within 24 hours after death To the Funeral Director: completely filled in by the	O	29a. Certifier 1 Certifying Phys	cian: To the best of my k	nowledge, death	occurred at the tim	e, date and place	e, and due to the	cause(s) and manner	r as stated.
	To the Ho within 24 To the Fu completel	Aedical	one) 2 Medical Examin	On the basis of examinand manner stated.	nation and/or in	estigation, in my op	oinion, death occi	urred at the time,	date and place, and o	due to the cause(s)
	or with	Σ	29b. Signature and title of certifier	land of		29c. License	number	53	29d. Date signed (Mo	onin, Day, Year)
	5		30. Name and address of person who cor	npleted cause of death (It	em 23a) (Type.	Print)	227	))	dis	106
1	-VA		Elaine SLOPA	D, M.D. 8	600 Old	Georgeto	wn Road	, Bethes	da, MD 208	314
	Sta Registr		31. Date filed (Month, Day, Year)	32 Registrar's Sig	nature	ules				

Max Pitch alaspor AAM

			1 - State Amend Item	State of Maryland 26 per drG854	/ Depa <b>04/4</b> ਟ੍ਰ	artment (	of Health	and M h	lental Hy	giene	06	07794
			Decedent's Name (First, Middle, Last)						2. Date of D	eath	Vana	3. Time of Death
ı	Physici /Medic		DONALD	RE	ONES				FEBRUA	RY 21.	Year 2006	1:10 P M
	Examir		4a. Facility Name (If not institution, give :	ŕ			wn, or Location				nty of Death	
			7051 Carroll Aver  5. Social Security Number 6. Sep		et hirthdayl	Tako	oma Par	k er 24 Hrs.	9 Date of Bi		tgome	ry place (State or Foreign
	Funeral Director			M 2□F 74	Yrs.		Days Hours		8. Date of Bi (Month, D) Jan	12, Year) 12, 193	2 Wasi	hington, D
	ט		Usual Residence of Decedent			1				,		
	anylar show		10a. State 10b. County		Town or Lo							10d. tnside City Limits 1 1 Yes 2 □ No
	he Mi	Director	Maryland Montgome	ery Tal	koma I				1	10 011	(111)	
	with t	D.	10e. Street and Number 7051 Carroll Aven	wo #207		10f. Zip Ci				10g. Citizen		
	ns 23	Funeral		12. Was Decedent Ever in U.S	. 13.	Was Deceder	t of Hispanic	Origin? (Spe	cify Yes or N		d Star	
aryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injugy or other traumatic event, the Medical Examinar must be notified at once.	by Fun	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Moivorced	Amed Forces? 1 ▼Yes 2 □ No If Yes, Give KOREA Year or Dates:		lf Yes, specify 1 ☐ Yes 2 <u>1</u>	Cuban, Mexic	an, Puerto	Rican, etc.)	E	Black, White, c <i>ity</i> ;	. etc. American
P	2 hot	Completed	15. Decedent's Edu (Specify only highest grad	cation	16a. Dece	dent's Usual (	Occupation done during m	ant of wards				ndustryLibrary
2	ithin 7	nple	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use	retired) -		ng	}		s Division
2	led w lygier her th	S	12		ASSI	stant	Manage		/E:	.1		her King
and	i be fi	Be	17. Father's Name (First, Middle, Last)							e, Maiden Sum	iame)	
Ž	hould d Me mark matic	유	Frank Rhones  19a. Informant's Name/Relationship (Ty	rne Print)	19b Mailie	na Address (S			e Myers	er, City or To	wn State Zin	n Code)
≥	od 2 s lith ar 27 is r trau		Hermione H. Rhone				St., M				712	, 66 <b>36</b> )
altimore,	s 1 ar f Hea item gother		20a. Method of Disposition	20b. Pla	ce of Dispo	sition (Name matory or othe	of		ate	20c. Location		own, State
Ę	Page nit.		1 ☐ Burial 2 ☐ X remation 3 ☐ P  `4 ☐ Donation 5 ☐ Other (Specify)	lemoval from State	•		natory	2/28	3/06	Belts	ville.	, Maryland
alti	partm porta y inju		21. Signature of Funeral Service License				-			ineral		
<u>m</u>	8 9 5 8		I Undre Ih	ompson	7	400 Ge	orgia	Ave. 1	N.W., V	Wash. D	.C. 2	20012
			23a. Part1. Enter the disease, or compli shock, or heart failure. List only or	ications that caused the death. ne cause on each line.	Do not ent	er the mode o	of dying, such	as cardiac o	r respiratory a	arrest,	-41441	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	CARDIO-PULMON	IARY A	RREST						Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a conseque	-							
		-		Due to (or as a conseque		EART DI	SEASE					
	nsit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	200 10 (07 20 2 00.100420								
,	execu n and ial-tra	Еха	that initiated events resulting in death) Last	Due to (or as a conseque	ince of);							
9/8	icate be executed physician and s the burial-transit	dical		1								
9	ntifica ng ph as th	Medi	IE EELALE.									
BOX	the death certific y the attending p sched for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregnand 1 Live birth 2 ☐ Fetal of		∃Ectopic preg	nancy				Date of deliv	
0.	e dea the at ned fo	sici	1 Yes 2 No	4☐Pregnant at time of dea 9☐ Unknown		Other (speci					Month	Day Year
J.	that the de led by the a detached t	Phy	Part II. Dther significant conditions cor	stributing to death but not result	ing in the u	nderlying caus	se given in Pa	rt (	23e Did	tobacco use c	ontribute to t	the cause of death?
Vital Records,	g g	d by				,	3. a			Yes 2 □ No		V
Ö	w require been si should I	Completed							24a. Was	24	h Were auto	opsy findings available
Ř	sician: The law certificate has b irector, page 2 s	дшо							auto		prior to co death?	ompletion of cause of
g		e C	25. Was case referred to medical				26 Pis	ice of Death	1 ☐ Yes (Check only		1 🗆 Yes	2[ <b>X</b> No
	> 0, 0	o B	examiner?	fospital: 1   Inpatient 2   E	R/Outpatier	nt 3 DOA	Othor			idence 6 🗆 (	Other (Special	(v)
0	ding Phys h. After this funeral di	n: T	27. Manner of Death 1 ▲Natural 5 □ Pending	28a. Date of Injury (Month, Day Year)	8b. Time o	f 28c	Injury at Work?			how injury occ		,
<u> </u>	endin sath. or: Af he fur	atlc	2 Accident investigation	(,,	,,	М	1 ☐ Yes 2	□No				
Division of	or Att iter de irect n by t	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At hom building, etc. (Specify)	ne, farm, str	eet, factory, o	ffice	2	28f. Location ( City or To	(Street and Nu wn, State)	mber or Rura	al Route Number,
	ors al		00 C 4 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1									
	Hos 24 ho Fun stely f	Medical	29a. Certifier 1 Certifying Physical Check only 2 Medical Examination	sicien: To the best of my know ner: On the basis of examination and manner stated.	edge, deat on and/or in	n occurred at vestigation, in	my opinion, d	and place, a eath occurre	and due to the	cause(s) and date and plac	manner as s e, and due t	tated. o the cause(s)
	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the funer	Me	29b. Signature and title of certifier	)	·	29c. L	icense numbe	ır		29d. Date sig	ned (Month,	Day, Year)
	5+1		17/7			#M	D 0101	041579	9 1	EBRUAR	Y 24.	2006
	יוכ		30. Name and address of person do co			Print)						
			LEE P. FERGUSON, M				IRVIN	G STRI	EET NW,	WASHI	NGTON,	DC 20422
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Signatu	re Andrew	Me						
	Registr	ar	FEB 2 8 200	U LINGE SELF	A. P. Contract	10000						

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 110L /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Cumberland
If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) SACred MEART Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex **Funeral** 1 M 2 F Months Days Hours Min 139-12-4575 Usual Residence of Decedent Yrs. Director 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State or 28a-f show treumatic event, the Medical Examiner must be notified at Yes 2□No Director 10e. Street and Number 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene important: if Item 27 is marked other than "natural", or Iteme 23a any piny or other treumatic event, the Medical Examples ORRE. Completed by Funeral . Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1□ Yes 22 No Specify 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Cook 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame, Be 2 Town, State 20a. Method of Disposition 20c. Location 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lice Sum Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final DAYS NEUMONIA **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Dualto (or as a societopeones of) Examiner inding physician and use as the burial-transit or Attending Physicien: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) P.O. Box 68760. Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant cate has been signed by the atter page 2 should be detached for u 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, DISEASE ARTERY 3 Probably 4 Unknown 1 ☐ Yes 2 No 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? IBRIL this certificate 2 No 1 Yes 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: Medical Certification: To 1 ☐ Yes 2 XNo 1 Inpatient 2 ER/Outpatient 3□ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of After 1 Natural 2 ☐ Accident 5 Pending 1 ☐ Yes 2 ☐ No death. investigation within 24 hours efter death To the Funeral Director; / completely filled in by the f 6 Could not be determined 28e. Ptace of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide the Hospitel 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one)

29b. Signature and title of certified

Registrar

State

D63118

900 SETON DRIVE, CUMBERLAND, MD 21502

(HOSPITAL

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

HASNAIN

29d. Date signed (Month, Day, Year)

03,08,2006

			For State Registrar	State	of Marylar		artmen rtificate			and M	ental H		ene ) (	Trappe of	7796
		8	1. Decedent's Name (First, Middle, Las	t)							2. Date of Month	Death	Day	Year	3. Time of Death
	Physici /Medic		Janet Josephine R	UST				,			Feb.	28	,		8:40 a. M
	Examin		4a. Facility Name (If not institution, give				4b. City,		Location of				4c. County o		
ski.		al .	Homewood at Willi						lliam	-					gton
	Funeral Director		721-03-3026	ax □M 2⊠F	7. Age (In yrs.	last birthday) Yrs.	If Under Months	Days	If Under Hours	Min.	8. Date of (Month, Feb.	Day, Y	1919	9. Birthi Cou Vir	place (State or Foreign ntry) ginia
	and w		Usual Residence of Decedent  10a. State 10b. County		10c. C	ty, Town or Lo	cation								I Od. Inside City Limits
	dary!	ō	Maryland Washin	oton		Hagers	stown								1 ☐ Yes 2 🔯 No
	28a-	ec.	10e. Street and Number	50011		114802	10f. Zip	Code				100	g. Citizen of W	hat Cou	ntry?
	3a or	۵	17231 Ontario Dr	ive			2	21740	)				USA		
	ms 2:	Funeral Director	11. Marital Status	12. Was Dec	edent Ever in U	J.S. 13.	Was Deced	lent of Hi	spanic Ori	gin? (Spe	cify Yes or Rican, etc.	No-			can Indian,
9	72 hours after death with the Maryland natural; or itams 23s or 28s-f show disal Examinar must be notified at	교	1 ☐ Never Married 2 ☐ Married		2 🔀 No		ryes, spec 1 □ Yes :		n, mexican Specify:	i, Puerto i	Hican, etc.,	1		, White,	
8	rai',	d by	3 ☐ Widowed 4 ☑ Divorced	If Yes, G Year or [	Dates:		1 1 1 6 5		Зреспу.				Specify:	WI	nite 
21215-0036	72 h 'natu	Completed	15. Decedent's Ed (Specify only highest grad		)	16a. Dece (Give	dent's Usua kind of wor DO NOT us	al Occupa nk done c	ation <i>Juring m</i> osi	t of working	ng	16	Sb. Kind of Bus	iness/Ir	dustry
121	within ene. then "	ш	Elementary/Secondary (0-12)	Coltege (	(1-4or 5+)	admin							rai	1roa	ıd
7	be filed within 72 hours after death with the Marylan stal Hygiene. ed other than "natural", or items 23e or 28a-f ahow avent, the Medical Exercinat must be notified at		17. Father's Name (First, Middle, Last)			dunizi	10010					idie. Ma	iden Sumame		
Maryland	Mental Mental arked o	To Be	John C. Rust, Jr	•							Peace			,	
<u> </u>	should be nd Mental marked umatic av	F	19a. Informant's Name/Relationship (7	ype, Print)		19b. Mailir	ng Address	(Street a	ınd Numbe	er or Rura	/ Route Nu	mber, (	City or Town, S	itate, Zij	Code)
	12 ha		Susan Chamblin -	cousin	n	1723	1 Ont	ario	Dr.	, Hag	gerst	own,	Md. 2	1740	
re,	s 1 a of Hei itam othe		20a. Method of Disposition		1	Place of Dispo cemetery, crei	sition (Nan	ne of ther plac	e)	D	ate	20	c. Location - (	City or T	own, State
E	Pages 1 and ment of Healt ent: If item 2 lury or other		1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify		i State	ion Ce				3/3/	06	L	eesburg	, V	irginia
Baltimore,	permit. Pag Depertment Important: I any injury o		21. Signature of Funeral Service Licen-	500	- (	22	2. Name an	d Addres	s of Facilit	У	MINNI	CH	FUNERAI	HO:	ME
<u>m</u>	88 = 8		2cott/	11/2	Much	4.	15 E.	Wil	son B	lvd.	, Hag	ers	town, N	ſd.	21740
8760,	Physician /Medical Examiner bhisician and physician and physician and the prijelitansit the prijelitansit	icai Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	(or as a conse	quence of):	e (h)	de	The state of the s	CUR	<i>-</i>		Tife		gews
P.O. Box 68	the death certifi y the ettending iched for use as	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 Live	utcome of pregribirth 2 Fet prant at time of nown	aideath 3	⊒Ectopic pr ⊒ Other (sp	3				_	23d. Date Mon		ery Day Year
	es tha gned be de	þ	Part II. Other significant conditions co	ontributing to	death but not re	sulting in the u	nderlying c	ause give	en in Part I			id toba	_		he cause of death?
Records,	The age	Completed									a	Vas an utopsy erforme	ed? de	ere auto for to co eath?	opsy findings available emptetion of cause of
Vital	ician: T certifical ector, p	BeC	25. Was case referred to medical examiner?						26. Place	of Death	(Check of				
of <	S S D	1 ☐ Yes 2 ★ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ★ Nursing Home 5 ☐ Re										Residen	ce 6 □Othe	r (Speci	fy)
ion o	ling After Tune	ation:	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation		of Injury nth, Day Year)	28b. Time o Injury	f M	8c. Injun Worl 1 □	vat k? Yes 2□		28d. Descr	ibe how	injury occurre	d	
Division	tal or Attends after death	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Pta c	e of Injury - At I ding, etc. (Spec	nome, farm, st ify)	reet, factory	, office				on (Stre Town,		r or Rur	al Route Number,
	To the Hospital or A within 24 hours after To the Funeral Dirac completely filled in b	edical	29a. Certifier (Check only one) (Check only one)	iner: On the											
	To the I within 2 To the I complet	ž	29b. Signature and title of certifier						number	an.	6		d. Date signed		
								0	00		0	1	C3/40	wy	28, 2005
			30. Name and address of person who	completed cau	of death (Ite		Print	N	do	·Va		-	2/	0 (/	28, 2005 2_
4	-4		31. Date filed (Month, Day, Year)	464	Yeurs Applistrar's Sign	Vante	Me	17	40	HU	in	7	a.	7	
	Sta Regist		MAR 0 1 2		ASTAN S SIGN	B. A.	per reflected								

Physician /Medical Examiner

> attending physician and for use as the burial-transit signed by the a d be detached for been si ctor: After this y the funeral o

The law requires that the death certificate be executed

death

within 24 hours of To the Funeral

Medical

Division of Vital Records, P.O. Box 68760

22. Name and Address of Facility
DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC.
1170 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 20852 23a. Part, Enter the hardse, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) acute myocardial insarction Due to (or as a consequence of): Due to for as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):

20b. Place of Disposition (Name of cemetery, crematory or other place)

GARDEN OF REMEMBRANCE 2/28/2006

Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐Yes 2 ☐ No 9☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 1 Yes 250No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 9000 2 R/Outpatient 3 DOA 1 Inpatient Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c, Injury at Work? 1 Natural 5 Pending М 1 Yes 2 No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide

29a. Certifier

1 Cretifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

(Check only one) 29b. Signature and title of certifier

19a. Informant's Name/Relationship (Type, Print)

4 ☐ Donation 5 ☐ Other (Specify)

21. Signature of Funeral Service Licensee

1 XBurial 2 Cremation 3 Removal from State

HELEN ROOT/WIFE

20a. Method of Disposition

29c. License number 036979

29d. Date signed (Month. Day, Year) February

Corner 925,2006

3. Time of Death

Birthplace (State or Foreign Country)

10d. Inside City Limits

1 ☐ Yes 2 X No

NEW YORK

20c. Location - City or Town, State

CLARKSBURG, MARYLAND

0555AM

elieghenie no 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

11

Rockwille mo 20850 mo 990) medical Center Dr.

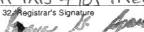
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

10113 GRAVIER COURT, MONTGOMERY VILLAGE, MD

State Registrar

31. Date filed (Month, Day, Year) FFR 2 7

Pelavah J. Shemi



DHMH 17 Rev 1/2001

Registrar

		1	= For Amend item#7,8	State of Ma B, perFH, G86	aryland / D ,11/27/06	epartment of H	ealth and N Death	lental Hygie	ne 0 0 6	07799
	Physicia	in	1. Decedent's Name (First, Middle, L	ast)	SHAP			2. Date of Death		3. Time of Death
	/Medic Examin		Aa. Facility Name (If not institution, go Hebrew Home of G	ive street and number)			Location of Death		4c. County of Dea	tgomery
	Funeral Director		066-38-6296	Sex 7. Ag	e (In yrs. last birti	hday) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth Oct., Pay, Ye	1932 9. Bir 1922 N&	thplace (State or Foreign W <sup>ntr</sup> York
	Maryland f show		Usual Residence of Decedent  10a. State 10b. County  MD MOntgo	omery	10c. City, Town	or Location ver Spring				10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	with the ? 3a or 28a- It be notifi	ā	10e. Street and Number 1113 Fairview Co	ourt		10f. Zip Code	0910	10g.	Citizen of What C	ountry?
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other then "naturel" or Items 23a or 28a-f show any injury or other treumatic event, the Medical Examinar must be notified at once.	by Fur	11. Marital Status 1 □ Never Married 2 ☒ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Armed Forces? 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates:		13. Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 No	spanic Origin? (Sp n, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Whi	te, etc.
21215-0036	within 72 hor ene. then "natur	Completed	15. Decedent's (Specify only highest g			Decedent's Usual Occup (Give kind of work done of life. DO NOT use retired Librarian	furing most of work		Library	·
land 2	ild be filed lental Hygi ked other ic event,	To Be Co	17. Father's Name (First, Middle, Las Charles Sha				18. Mother's Nam	e (First, Middle, Mai ie Koh	den Sumame) Lberg	
Baltimore, Maryland	alth and Malth and Malth and Marth a		19a. Informant's Name/Relationship Lisa Shames	(Турв, Print) daughter	19b.	Mailing Address (Street and 11112 Ralsto	and Number or Rui on Rd., R	a <i>l Route Number, C</i> ockvill <b>e</b> ,	ity or Town State, MD 20852	Zip Code)
imore,	Pages 1 and ment of He ant: If item		20a. Method of Disposition 1   Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spec	□Removal from State	cemeter	Disposition (Name of y, crematory or other place avid Cemeter	y Feb.2	7,2006 E	Lmont, N	
Balti	permit. Departn Importa any injit		21. Signature of Fureral Jeryice up	12/		254 Ca	rroll St	., NW , W	ashingtor	neral Home , DC 20012
	Physician /Medical	e 1	23a. Part1. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)	a	ASTA			or respiratory arrest,	_	Approximate Interval Between Onset and Death
	Examiner	er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. PNO	a consequence	10NIA				<del></del>
8760,	death certificate be executed e attending physician and d for use as the burial-transit	dical Examiner	causé. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as	a consequence	of):				
9	tificate ng phys as the	Medic	(ESEMALE	u.						115
O. Box		by Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify) _			23d. Date of de Month	olivery Day Year
Δ.	requires that the een signed by th hould be detache	ed by Ph	Part II. Other significant conditions	s contributing to death I	out not resulting in	n the underlying cause giv	en in Part I.	23e. Did tobad	. /	o the cause of death? Probably 4 □Unknown
of Vital Records,	2 S	Completed						24a. Was an autopsy performe 1 ☐ Yes 2 ☑	prior to d? death?	utopsy findings available completion of cause of s 2 \( \text{ No} \)
/ita	Physicien: The l this certificate har ral director, page	Be	25. Was case referred to medical examiner?	Hospital:		Oth	1/	th (Check only one)		
of	문 부 Ta	. To	1 ☐ Yes 2 ♠ No  27. M. ny -r of Death	28a. Date of Inj (Month, Date		Time of 28c. Injur	4 Whursing H	ome 5 Residence 28d. Describe how		ecify)
Division	To the Hospital or Attending Phy within 24 hours after death. To the Funerel Director: After thi completely filled in by the funeral	Certification:	1 Natural 5 Pending 2 Accident 3 Suicide 6 Could no determine	t be 28e. Place of Ir			k? Yes 2 □ No	28f. Location (Stree City or Town, S	et and Number or l State)	Rural Route Number,
	Hospital 24 hours a Funerel C etely filled	edical Ce	29a. Certifier 1 Certifying (Check only one)  2 Medical Ex	Physician: To the best caminer: On the basis and manner's	of examination an	e, death occurred at the tire d/or investigation, in my d	me, date and place pinion, death occu	, and due to the caus rred at the time, date	se(s) and manner a and place, and du	as stated. se to the cause(s)
	To the To the comple	Me	29b. Signature and title of certifier	n Mill	My.	H.D 29c. Licens	359	36 Ft	Date signed (Mon	nth, Day, Year) 14 25, 2006
	10		30. Name and address of person with	no completed cause of	death (Heat 23a)	Cype, Print) Barre	to KA	DAY 2	085	2
1	St Regist		31. Date filed (Month, Day, Year) FEB 2 8	2006 32 Regis	trar's Signature	Sperte				

State of Maryland / Department of Health and Mental Hygiene For Stata Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) February **Physician** ELIZABETH 2006 Τ. SHERWOOD 9:45 A M /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Bedford Court Skilled Nursing Center Silver Spring Montgomery If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Yeer) Birthplece (State or Foreign Country) **Funeral** 1 M 2 YF 216-74-5375 96 Sept. 14 1909 New York Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County od other than "natural", or items 23a or 28a-f show event, it a Medical Erand er must be notified at 1 Yes 2 No Montgomery Silver Spring Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20906 United States #732 3701 International Drive deeth Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be fited within 72 hours after of oppartment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Ite 1 Never Married 2 Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify. þ 3 ⊠Widowed 4 □ Divorced Year or Dates Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15 Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John Reid Tulloch Ida White 2 injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Douglas R. Sherwood / Son 5800 Griffith Road, Laytonsville, Md. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Metropolitan Crem. 3/1/06 Alexandria, Va. \*4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
Muriel H. Barber Funeral Home P. O. Box 5038, Laytonsville, Md. 20882 Approximate Interval Between Onset and Death Y.C.C.S. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition **Physician** resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed and Due to (or as a consequence of): the attending physicien Completed by Physician/Medical as the use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ŏ in the past 12 menths? 1 ☐ Yes 2 ☑ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown signed by significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, pe 4 Onknown 3 Probably 1 ☐ Yes 2 ☐ No director, page 2 should peeu 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy performed: 1 Yes 2 No Hospital or Attending Physician: Skilled 26. Place of Death (Check only one. Be 25. Was case referred to medical examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Nother (Specify) Nursing 1 Tyes 2 No 2 ER/Outpatient 3 DOA Certification: To 1 Inpatient this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation 1 V aturai 1 ☐ Yes 2 ☐ No death. 2 Accident the 24 hours after death Funeral Director: 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) completely within 2 To the I the 29d. Date signed (Month, Day, Year) of certific and little 29b. Signature 2 leted cause of death (Item 23a) (Type, Print) 30. Name and address of persy 31. Date filed (Month, Day, Year) State 28 FEB 2006

Registrar

P.O. Box 68760.

			1 - For State Registrar	State of Ma	aryland		artment tificate			and Me		giene	6	07801
	Physicia	an	1. Decedent's Name (First, Middle								2. Date of Dea Month	Day	Year	3. Time of Death 1:45 A. M
	/Medic	al	Walter Alle		re		4h Cin. 1	Tauan au	l continu		Februar	y 24, 2	2006	
1	Examin	er	Wilson Health				-		Location of Sburg			Monte		
	Funeral		5. Social Security Number	6. Sex 7. Ag	e (In yrs. las	st birthday)	If Under		If Under	24 Hrs. Min.	8. Date of Birth (Month, Day	Year)	9. Birth	place (State or Foreign
	Director		577-01-9703	1 XM 2 ☐ F	100	Yrs.	Months	Days	Hours	Will.	Nov. $4$ ,	1905		iessee
	and w		Usual Residence of Decedent  10a. State 10b. County	,	10c. City,	Town or Lo	cation							10d. Inside City Limits
	Maryl -f sho	to	Maryland Montg	omery	Gai	thers	sburg							¥EYes 2□No
	h the	irec	10e. Street and Number				10f. Zip					10g. Citizen of		-
	23e c	rai D	301 Russell Av	enue 				2087				United		
	er dez	nne	11. Marital Status	12. Was Decedent Armed Forces?		13. V	Was Deced f Yes, spec	ent of Hi ify Cubai	spanic Ori n, Mexican	gin? (Spec 1, Puerto F	cify Yes or No- Rican, etc.)	14. Rac Bla	ce - Ameri ck, White,	can Indian, , etc.
336	urs aft	by F	1 ☐ Never Married 2 ☐ Married 3 🔀 Widowed 4 ☐ Divorced	If Yes Give	NO		I□Yes 2	No No	Specify:			Specif	y: Whi	te
21215-0036	72 hor	Completed by Funeral Director		nt's Education est grade completed)		16a. Deced	lent's Usua	l Occupa	ition	t of workin	a	16b. Kind of B	lusiness/Ir	ndustry
2	vithin ne. <b>hen</b> "	mpie	Elementary/Secondary (0·12)	College (1-4or 5	5+)		kind of wor DO NOT us il sa		)		3	Pharm	aceut	ical
7 q	filed within 72 hours after death with the Maryland Hygiene. uther then "neturel", or Items 23e or 28e-1 show ant, the Medical Examiner must be notified at	CO	17. Father's Name (First, Middle,	5+		Ne ca.	II sa	162	18. Mothe	er's Name	(First, Middle,	Maiden Sumar		
an	ild be lental ked o ic eve	To Be	Walter Ernest						Por	rtia	Allen			
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: if I tem 27 is marked other then "neturef", or Items 23e or 28e-1 show any injury or other treumetic event, the Medical Examiner must be notified at ones.	_	19a. Informant's Name/Relations Walter A. Shro		on '	19b. Mailin 4816	g Address F1owe	(Street a	nd Numbe	or Aural Driv	Route Numbe	r, City or Town	, State, Zi <sub>l</sub> MD 20	p Code) <b>085</b> 3
ore,	of Hee		20a. Method of Disposition 1  Burial 2  Cremation	2 Demoval from State	20b. Pla	ce of Dispo	sition (Nan	ne of therplace	왕+v I	D: Febru	ate arv25	20c. Location	•	
Ĕ	Pag ment ent: f		'4 MDonation 5 ☐ Other (S			ical (	Cente	r		200	6	Washin		
Baltimore,	permit. Depart Import any inj		21. Signature of Funeral Service	u Perch		22						ortuary ington,		vices, Inc. . 20037
			23a. Part1. Enter the disease, or shock, or heart failure. List	t only one cause on each li	ne.							rest,		Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Aclude Due to (or as	txo	ule	eri	10	Ch	Lu	ce			Bovelles
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Box 6	Attending Physicien: The law requires that the death certificate be executed in death. If death. ector: After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome 1□Live birth			Ectopic pr	0000000				23d. Da	ate of deliv	•
Э. В	that the death ed by the atte detached for	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at			Other (sp.					Me	onth	Day Year
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000	aw requir is been si 2 should	piete	Remotice	relucion	esci	ela s	- ac	cid	eul	4	24a. Was autop	an 24b.	Were aut	opsy findings available ompletion of cause of
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of\	Physic this c	10 10	1 Yes 2 No	1 Inpatie	ent 2 El	R/Outpatien		8c. Injury				ence 6 Otl		(fy)
O	ding Ith. th. After funer	tlon	1 ☑Natural 5 ☐ Pendir	28a. Date of Injung (Month, Date of Injunction)	y Year)	Injury	M	Work	(?` ∕es 2 🔲		54. B636/105 II	ow injury coods		
Division of Vital Records,	7 4 7	Certification:	3 Suicide 6 Could 4 Homicide determ	nined   286. Place of Inj	ury - At hom c. (Specify)	ie, farm, str	eet, factory	office	- W-	2	8f. Location (S City or Tow	Street and Number, State)	ber or Rur	ral Route Number,
_	To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	edical C	29a. Certifier 1 Certifyin (Check only one) 2 Medicel	ng Physicien: To the best Exeminer: On the basis o and manner st	f examination	ledge, death on and/or inv	occurred vestigation,	at the tim	ie, date an pinion, dea	nd place, a ith occurre	nd due to the o	cause(s) and m date and place,	anner as s	stated. to the cause(s)
	To th withir To th compl	Me	29b. Signature and title of certifie						number			29d. Date signe		
<b>)</b>	10		1 Kl Dohei	torrsin	line	l.us	5)	10	4/1	15	7	telunco	reef	24,2006
			Manual and address of person 14. RUBERTB	who completed cause of course of Cou	teath (Item 2	23a) (Type,	Print)	40	1718	K7 B1	CLAC	ENLLE	208	49
	Sta Registr		14. ROBERTS 31. Date filed (Month, Day, Year, FEB 28	2006 32 Registr	ar's Signatu	re And	nde				·			

Physici	an	Decedent's Name (First, Middle, L JOSEPH EDWARD SP	Last)	_, _		FIGAS SH		2. Date of De Month	Day 25	Year Dato	3. Time of Death
/Medic Examin		4a. Facility Name (If not institution, g	give street and number)			4b. City, Town, or LEONAR	Location of Death	عر ن	4c. Cou	nty of Death	
Funeral	145	Social Security Number 6.	. Sex 7. Age	e (In yrs. la	last birthday)		If Under 24 Hrs. Hours Min.	8. Date of Bir	th Year) 25,1932		ace (State or Fore
Director		214-30-0413 Usual Residence of Decedent	X M 2□F	74	Yrs.	Months	Tiours Will.	FEBRUARY	25,1932	MARY	LAND
nyland ihow		10a. State 10b. County		10c. City	y, Town or Lo	ocation				10	d. Inside City Limi
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r death	Funerai	11. Marital Status	12. Was Decedent E	Ever in U.S	S. 13.	Was Decedent of Hi If Yes, specify Cuba	ispanic Origin? (Sp In. Mexican, Puerto	pecify Yes or No	o- 14. F	lace - America llack, White, e	ın Indian,
72 hours after natural', or ita	by F.	1 ☐ Never Married 2 🛣 Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces?  1 Yes 2 N If Yes, Give Year or Dates:	10		1□Yes 2XNo	Specify:	, , , , , , , ,		cify: BLAC	
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within one.	Completed	Elementary/Secondary (0-12)	College (1-4or 5-	+)		kind of work done of DO NOT use retired		ung	CONTO	IDI IOMTO	<b>.</b> 7
000	0	5TH GRADE  17. Father's Name (First, Middle, La.	15t)		ASPHA	LT PAVING	18. Mother's Nam	e (First, Middle		RUCTIO	N .
d b	To B	JOSEPH SPEARS					TERESA S'	reward :	SPEARS		
2 sho and is m		19a. Informant's Name/Relationship				ng Address (Street a					
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			1 - For State Registrar	State of Ma			of Health and of Death		iene () () 6	07803
			Decedent's Name (First, Middle, I	Last)				2. Date of Deat		3. Time of Death
	Physici		Larry A1	an Spe	eckmeier			February	27, 2006	5:22 A M
	/Medic Examin		4a. Facility Name (If not institution, g	give street and number)		4b. City, To	wn, or Location of Dea		4c. County of Dea	
			5105 Bluehead Co	ourt			Waldorf		Charle	S
	Funeral		Social Security Number 6.		e (In yrs. last birthda	y) If Under 1 \ Months   D	Year If Under 24 Hrs Days Hours Min		Year) C	thplace (State or Foreign ountry)
	Director		212-68-1775	1 <b>⊠</b> M 2□F	51 Yrs.		,	Sept. 18	3, 1954Min	neśota
	DG &		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or	Location				10d. Inside City Limits
	aryla •ho	ž		7	100. 0, 10111101	Loodion	V-7 1- 4	-		1 ☐ Yes 2 🔀 No
	Ne N	Directo	Maryland Cha	arles		10f. Zip Co	Waldorf		0g. Citizen of What C	ountry?
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	item item	Funerai	1 □ Never Married 2 🔀 Married	Armed Forces?		If Yes, specify	Cuban, Mexican, Pue	rto Rican, etc.)	Black, Wh	
36	rs af	by F	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 🖔	No Specify:		Specify: W	nite
ğ	filed within 72 hours after deeth with the Maryland Hygiene. other then "natural", or items 23s or 28s-f ehow ent, the Medical Examinational be notified at	ed	15. Decedent's			edent's Usual C			16b. Kind of Business	
끘	n u	Completed	(Specify only highest of Elementary/Secondary (0-12)	grade completed)  College (1-4or 5	life	DO NOT use	done during most of wo retired)	orking		
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פ	oth y	Bec	17. Father's Name (First, Middle, La	st)			18. Mother's Na	me (First, Middle, M	Maiden Surname)	
<u> </u>	uld b Ments rrked rice	Tof	Clarence Speckme	ier			Gladys	Mae White		
ary	and be		19a. Informant's Name/Relationship			iling Address (S	Street and Number or F	lural Route Number,	City or Town, State,	Zip Code)
Σ	and 2 selth n 27 i		Janet Lynn Speck	meier / Wif	A		ad Court,			
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylan Department of Heelih and Mental Hygiene. Important: if item 27 is marked other then "natural; or items 23a or 28e-f show any injury or other traumatic event, the Mudical Examination and be notified at another.		20a. Method of Disposition 1 □ Burial 2 🖾 Cremation 3	□ Romoval from State	20b. Place of Dis	position (Name rematory or othe	of May	ch 2,	20c. Location - City o	Town, State
Ĕ	Page ment ant: if		4 □ Donation 5 □ Other (Spe		Huntt C	rematory	/ 200		Waldorf, M	aryland
<u>a</u>	Departr Departr Imports any inju		21. Signature of Funeral Service Lic	ensee M01391		22. Name and	Address of Facility		d Washing	
Ω	89 5 8 8		John High			luntt Fu	neral Home	POB 156	Waldorf,	MD 20604
			23a: Part1. Enter the disease, or co shock, or heart failure. List on	omplications that caused tly one cause on each lir	the death. Do not e	enter the mode o	of dying, such as cardia	ac or respiratory arre	est,	Approximate Interval Between
Ш	Physician		Immediate Cause (Final disease or condition	Miss	cardenal	Tarta	mt.			Onset and Death
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	D #	lner	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Du to as	a c nsequence of):					
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9 X	The law requires that the death certific is that been signed by the ettending page 2 should be detached for use as:	Physician/Me	IF FEMALE:	22a If was sutesma	of accessors.					
Вох	ath c	lan	23b. Was decedent pregnant in the past 12 months?		2 Fetal death	3 ☐Ectopic preg			23d. Date of de Month	Day Year
o <u>.</u>	the e	/sic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□ Pregnant at 9□ Unknown	time of death	5 ☐ Other (spec	rfy)			
<u>.</u>	that the de led by the detached		Part II. Other significant conditions	s contributing to death b	ut not resulting in the	underlying cau	se given in Part I	23e. Did tob	pacco use contribute	o the cause of death?
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ec €	hast hast	Completed	( leve Dro	YOSCERA	EVYU			24a. Was a autops perform	y prior to	utopsy findings available completion of cause of
픋				1						s 2□No
Ë	Attending Physicien: The death. c death. ector: After this certificete by the funeral director, pag	Be	25. Was case referred to medical examiner?	Hospital:			Other	eath Check only on		
5	Phys this	7°	1 Yes 2 No 27. Manner of Death	1 L Inpatie			4   Nuising	7 4	ence 6 Other (Sp.	ecify)
5	Jing After funer	o E	1 Natural 5 ☐ Pending	28a. Date of Inju- (Month, Da)	y Year) Injur	M EBC	. Injury at Work? 1 ☐ Yes 2 ☐ No	Edg. Describe No	w mjury occurred	
<u>s</u>	death death ctor: A	ica	3 Suicide 6 ☐ Could no	t be 290 Place of lair	ury - At home, farm,			28f. Location /St	reet and Number or F	Pural Route Number
Division of Vital Records,	5 5 th 6	Certification:	4 ☐ Homicide determine	building, etc	c. (Specify)	311001, 140019, 1	,,,,,,	City or Town		
_	To the Hospitei or Attending I within 24 hours after death.  To the Funeral Director: After completely filled in by the funer		29a. Certifier 1 Certifying	Physician: To the best	of my knowledge, de	ath occurred at	the time, date and plan	e, and due to the ca	ause(s) and manner a	s stated.
	24 h	edicai		caminer: On the basis of and manner sta	f examination and/or					
	To the within 2 To the complet	₹ E	29b. Signature and title of certifier			29c. l	icense number	2	9d. Date signed (Mor	th, Day, Year)
)	- > - 0		X78 -	PY 1	and 1	T	01922		22 Feb 6	0000
(			30. Name and address of person wh	no completed cause of d	leath (Item 23a) (Tvo	ne, Print)				
1	B3		7 I Fred	dsa M	1)	Mala	o. S. Mr	201501	f	
	Sta	ite	31. Date filed (Month, Day, Year)	32. Pojistra	ar's Signature	1 18.	, , , , ,			
7	Registi		FEB 2	8 2006	va S.	GOODS				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For Stata Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 40 AM 12 Ernest William Sprinkle 2006 0 /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Washington Coffman Nursing Home Hagerstown If Under 1 Year If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min tXXM 2□F 220-28-8292 83 Yrs. Director West Virginia Sept.27,1922 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a State 10h County 10d. Inside City Limits 28a-f show traumatic evant, the Medical Exactiner trust be notified at 1 Yes 2 No Director Maryland Washington Williamsport 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 0 21795 USA 111 West Potomac Street Itams 23a Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 Never Married 2 Married 6 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: White 3 Widowed 4 Divorced 'naturat', 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) 2 should be filed within and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Custodian Church 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Clara Catherine Jacobs Elgie Costello Sprinkle 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If itam 27 Is any injury or other tra Carolyn D. Forsythe - Niece Hagerstown, MD 21740 17512 York Rd. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Greenlawn Mem. Park Mar.1,2006 Williamsport, Maryland \* 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Lice 22. Name and Address of Facility Osborne Funeral Home, P.A. 425 S.Conococheague St. Williamsport, MD 21795 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause in each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 10-/Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (o burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) nding physician Physician/Medical the Vame Frough to Physician IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown ignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ celle 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an has autopsy performed 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death-(Check only one) Hospital: Other: 4 Hursing Home 2 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Hospital or Attanding 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident investigation Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funaral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only onel 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed dause of death (I) 23a) (Type, Print) Muc 31. Date filed (Month. 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

		·	For State Registrar	State	of Marylan		artment rtificate			and M		giene () (	16	07805
3	Physici	an	Decedent's Name (First, Middle, Last	st)							2. Date of Dea Month	ith Day	Year	3. Time of Death
	/Medic		Shirley Irene								Februa:			9:00 Р м
	Examin	er	4a. Facility Name (If not institution, give		- '- '		4b. City, T			f Death			ty of Death	-1-
-	Funcial		Frederick Memo  5. Social Security Number 6. S		7. Age (In yrs. I	ast birthday)	If Under 1		ick If Under 2	24 Hrs.	8. Date of Birt	h	ederic 9. Birth	place (State or Foreign
ı	Funeral Director			□ M 2 1 1 F	87	Yrs.	Months	Days	Hours	Min.	$\operatorname{Dec.12}^{(Month, Da)}$	1918	Mary	yland
	P _		Usual Residence of Decedent											
	arylar ehow	-	10a. State 10b. County	•		, Town or Lo								10d. Inside City Limits 1 ☐ Yes 2 🛂No
	28a-f	ecto	Maryland Frederic	K		Thurmo		2 and a				10g. Citizen o	( ) Milhau Carr	
	with a or i	ā	7013 Kellys Stor	e Road			10f. Zip C	2178	38			-	SA	illi y r
	tiled within 72 hours after death with the Maryland Hygiene. other than "naturel", or iteme 23a or 28a-f ehow ent, the Madical Examiner mutt be notified at	Funeral Directo	11. Marital Status	12 Was Dec	edent Ever in U.	S. 13.1				gin? (Sp	ecify Yes or No- Rican, etc.)		ace - Ameri	
٥	or ita		1 ☐ Never Married 2 Married	Armed F 1 Tes If Yes, G	2 🔼 No		fYes, specif 1 ☐ Yes 2		n, Mexican  Specify:	, Puerto	Rican, etc.)		ack, White, <sub>ify:</sub> Whit	
5-0036	ural',	d by	3 ☐ Widowed 4 ☐ Divorced	Year or [	Dates:							Spec	ny: •••••	
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0	be tiled within 72 hours after death with the Marylan ital Hygliene. Id other than "natural", or iteme 23a or 28a-1 show event, the Madical Examinar must be notified at	Be C	17. Father's Name (First, Middle, Last,			<u> </u>			18. Mothe	r's Nam	e (First, Middle,	Maiden Suma	ime)	
<u>ja</u>		To B	James Edga	r	Miller				Ma	ry	Cat	herine	St	itley
Maryland	s 1 and 2 should if Health and Mer item 27 is marke other traumatic		19a. Informant's Name/Relationship ( Ernest L. Sunday/		1						a <i>l Route Numbe</i> d <b>Thur</b> i			
ē,	s 1 ar		20a. Method of Disposition		20b. P	lace of Dispo	sition (Name	e of			Date	20c. Location		
Ē	Pages nent of ant: If it		1X Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specif			t HAve	n Mem	. Ga	ard   1		2,2006		-	
Baltimore,	permit. Pages Department of I Important: If it any injury or o		21. Signature of Fringeral Service Acer	tsee							auffer ; , Thurm			
T			23a. Part1. Enter the disease or com shock, or heart failure. Ust only	plications that	caused the death	n. Do not ent	er the mode	of dying	g, such as	cardiac	or respiratory ar	rest,		Approximate Interval Between
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. E.	/Medical Examiner		resulting in death)	Due to	(or as a consequ	uence of):								
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	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events			,								
o Î	an an		resulting in death) Last	Due to	(or as a consequ	uence of):								
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īd	v require been sig should b										1 🗆 Y	'es 2□No	3 🗌 Prol	bably 4 Onknown
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0	Physic rthis ral dir	To.	1 Tes 2 No 27. Manner of Death	Hospital: 1 []		ER/Outpatier 28b. Time o			4 🗆 140	rsing Ho	me 5 Resid			<i>fy</i> )
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ā	s afte	Certification:	4   Homicide	build	ling, etc. (Specify	V)					City or Tow	m, State)		
	To the Hospital or Atte within 24 hours atter de To the Funeral Directo completely filled in by th	edicai	29a. Certifier 1 Certifying Pt (Check only one) 2 Medical Exam	niner: On the l and mai	basis of examinal nner stated.	tion and/or in	vestigation, i	in my of	oinion, dea	th occur	red at the time,	date and place	and due t	o the cause(s)
	To th withir To th compl	Me	29b. Signature and title of certifier	/			29c.	License	number	_		29d. Date sign	ned (Month,	Day, Year)
)			1/7/	Cu.	NO		1	)00	0351	52		2	270	6
	H		30. Name and address of person who	completed cau	use of death (Item	23a) (Type,	Print)	. 5	J	Th	urmon	, m	10 2	21788
September 1	Sta Registi		31. Date filed (Month, Day, Year)	006 32.	ise of death (Item	B 19	porti							

			For 1 State	State of M		Department of	Health and	Mental Hyg	giene	n7806
			1 - State Registrar  1. Decedent's Name (First, Middle,	Lacti		Certificate o	r Death	2. Date of Dea	leg. No. UUU	3. Time of Death
	Physici	an		Last)		Sel	11+2	Month	Day Yea	11/25 04
-	/Medio		4a. Facility Name (If not institution,	give street and number			, or Location of Deat	TE DRUM	4c. County of D	7
1	Examir	ier	The John a	Unaber	Usa.L.	1 504	NERE		, , , , ,	
	Funeral Director		5. Social Security Number 216-36-7265	6. Sex 7. Ag	ge (In yrs. last bir	thday) If Under 1 Yes Months Day	ar If Under 24 Hrs.	8. Date of Birth (Month, Day Sept 14		Birthplace (State or Foreign Country) Maryland
	pu ,		Usual Residence of Decedent		10c. City, Tow	!!		1	,	
	show	7	10a. State 10b. County							10d. Inside City Limits 1 ☑ Yes 2 ☐ No
	he M	ecto	MD		Baltin				10- 03	21
	with t	Ē	10e. Street and Number	7 4		10f. Zip Code			10g. Citizen of What	Country?
	eath	eral	35 N. Lakewoo	D AVENUE 12. Was Decedent	Ever in II S	21224	f Hispanic Origin? (S	necify Yes or No-	USA 14 Bace - A	merican Indian,
36	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 Is marked other than "natural", or Items 23s or 28s-f show other traumatic event, It a Mystical Examinational Remarker Inditional	by Funeral Director	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces	?	If Yes, specify C	uban, Mexican, Puer	o Rican, etc.)	Black, W	
21215-0036	hour	edt	15. Decedent		16a.	Decedent's Usual Occ	cupation		16b. Kind of Busine	<del></del>
15	in 72	Completed	(Specify only highes	grade completed)		(Give kind of work dor life. DO NOT use ret	ne during most of wor	rking		,
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b	e filec I Hyg othe	Be C	17. Father's Name (First, Middle, L	ast)			18. Mother's Nar	ne (First, Middle,		202 11001
an	should be nd Mental marked o	To B	Harry Albert	Schultz			Mary I	rene Gro	ve	
Maryland	2 shou and N Is mai		19a. Informant's Name/Relationsh		19b	. Mailing Address (Stre				e, Zip Code)
	Health a tem 27 ls		Terry L. Schult	z - Nephew	- 3	09 S. Main	Street -	Mercers	bure. PA 1	17236
J.			20a. Method of Disposition	~	20b. Place of	Disposition (Name of ry, crematory or other p	place)	Date	20c. Location - City	
E	Pages nent of h ant: If ite ury or of		1 ☐ Burial 2 ☐ Cremation 1 ☐ Donation 5 ☐ Other (Sp	3 ∐Hemoval from State ecify)		town Crema	1 .	/06	Ha erstown	n MD
Baltimore,	permit. Page Department o Important: If any injury or once.		21. Signature of Funeral Service L	icensee		22. Name and Add	tress of Facility			
m	90 = 9	18 0	Robert L.	Jew-	M970				encer Fund	
	F		23a. Part1. Enter the disease, or shock, or heart failure. List of	omplications that cause	d the death. Do i	not enter the mode of d	lying, such as cardiac	or respiratory arr	est, y, wv 2.	III/CI AGI DOTAGOII
	Pnysician	es s	Immediate Cause (Final disease or condition	stre	shee					Onset and Death
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Box	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal death	3 □Ectopic pregna 5 □ Other (specify)			23d. Date of o Month	delivery Day Year
P.O.	res that thighed by		Part II. Other significant condition	ns contributing to death t	out not resulting is	n the underlying cause	given in Part I.	23e. Did to	bacco use contribute	to the cause of death?
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CO	w require been signature	Completed	/		,	( )-		24a. Was a	an 24b. Were	autopsy findings available
Re	he lav	duc						autops	rged? prior death	to completion of cause of ?
Vital	ician: Th certificate rector, pag	O O	25. Was case referred to medical				26 Place of Dea	1 Tes	2 No 1 Y	es 2 No
>		0 8	examiner?	Hospital:	ent 2 ER/Ou	stpatient 3 DOA	Other: 4 Nursing H			necify)
of	P F la	E :	27. Manner of Death	28a. Date of Inju	ary 28b.	Time of 28c. In			ow injury occurred	
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Division	after de Directo	Certification:	3 Suicide 6 Could n 4 Homicide determi	286. Place of in	jury - At home, fa tc. <i>(Specify)</i>	rm, street, factory, offic	е	28f. Location (S City or Town		Rural Route Number,
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Medical C	29a. Certifier (Check only one)	Physician: To the best xaminer: On the basis of	of my knowledge of examination an	e, death occurred at the d/or investigation, in m	time, date and place y opinion, death occu	e, and due to the corred at the time, d	ause(s) and manner late and place, and c	as stated. lue to the cause(s)
	orthin	Me	29b. Signature and title of certifier		- 3-1	29c. Lice	ense number	2	29d. Date signed (Mo	onth, Day, Year)
	->-0		1000	2 20		Do	06368	ر ا ر	Se h e	76 2006-
	4		30. Name and address of person v	tho completed cause of	death (Item 23a)	(Type, Print)	,,		(3/047)	Ca, 2006
	5		matthew to	enio 600	n h	olfe St	Baltin	ore M	D 2128	7
÷	Sta Registi		31. Date filed (Month, Day, Year) MAR 0	The demptor cause of 2 2006 32. Refirst	rar's Signature	Sperle		1		
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DHMH 17 Rev 1/200

Registrar

		-	Signal Si	tate of Marylan		artment of F		nd Mental Hy	/giene Reg. No.	J 0 6	07808
	Dhusisi		1. Decedent's Name (First, Middle, Last)					2. Date of D Month	eath Day	Year	3. Time of Death
	Physicia /Medic	al .	Nancy Ricker Samis					Februa	ary 2	2 200	
	Examin	er	4a. Facility Name (If not institution, give stree	_		4b. City, Town, o		City	4c. 0	County of Deat	:h
			Sinai Hospital of  5. Social Security Number 6. Sex	Baltmar 7. Age (In yrs.		If Under 1 Year			irth	9. Birt	hplace (State or Foreign
	Funeral Director		001-28-5013		Yrs.	Months Days		Min. 8. Date of B (Month, D	ay, Year) . 193	8 New	Hampshire
			Usual Residence of Decedent								
	arylar show	_	10a. State 10b. County	10c. Cit	ty, Town or Lo	ocation					10d. Inside City Limits 1 ☐ Yes 2 🕅 No
	8a-f	ecto	Maryland Anne Aruno	lel Mi	illersy				10 - Citin	en of Whal Co	
	with to	Ö	10e. Street and Number			10f. Zip Code 21108				ted Sta	
	ns 23	eral	836 Generals Highway	Was Decedent Ever in U	.S. 13.		Hispanic Origin	n? (Specify Yes or N Puerto Rican, etc.)		4. Race - Ame	erican Indian,
(0	r Iten	F	1 Never Married 2 Married	Armed Forces? I∐Yes 2⊠No				Puerto Rican, etc.)		Black, Whit	
8	rel', o	by	3 X Widowed 4 ☐ Divorced	f Yes, Give Year or Dates:		1 ☐ Yes 2 🌠 No	Specify:			Specify: Wh	1116
Maryland 21215-0036	72 h	Completed by Funeral Director	15. Decedent's Education (Specify only highest grade control of th	n m <i>pleted)</i>	(Give	dent's Usual Occup kind of work done	during most o	of working	16b. Kin	d of Business/	Industry (Industry
2	vithin ne. han	ldm	, , ,	Coltege (1-4or 5+)	1	DO NOT use retire			D.	etail S	The we
D D	Hygie thar t	ပိ	17. Father's Name (First, Middle, Last)		Ų. UE	afeteria	7	s Name (First, Middl			tore
au	ld be ental ked o	То Ве	Russell A. Ricker				Laura	M. Colli	er		
ary	shou nd M mar	-	19a. Informant's Name/Relationship (Type,	Print)				or Rural Route Num			
	and 2 alth a 127 Is		Russell A. Ricker, S					y Miller	svill	e, Mary	land 21108
ore	es 1 g	0 0	20a. Method of Disposition	20b. F	Place of Dispo cemetery, crei	osition (Name of matory or other pla	сө)	Date	20c. Loc	cation - City or	Town, State
Ĕ	Pag ment ant: h		1 Burial 2 □ Cremation 3 □ Remo '4 □ Donation 5 □ Other (Specify)	Lal							lle, Marylan
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel; or items 23a or 28a-f show any injury or other traumatic event, Ite Mariled Examiner must be notified at 200.		21. Signature of Funeral Service Licensee	,							cal Home,Inc ls, MD 21401
			23a. Part1. Enter the Isease, or complication shock, or heart failure. List only one cannot be a second sec	ons that caused the dear ause on each line.	th. Do not en	ter the mode of dyi	ng, such as ca	ardiac or respiratory	arrest,		Approximate Interval Between Onset and Death
1	Physician <sup>*</sup>	1 1	Immediate Cause (Final disease or condition	Sersi	2						2 days
	/Medical Examiner	l A	resulting in death)	Due to (or as a consec							2 days
		<b>1</b> 77	Sequentially list conditions, b	Due to (or as a consec	mon!	~					L days
	ted nsit	nin	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Closes of highly)								
Ć,	execu n and ial-tra	Examiner	that initiated events c. resulting in death) Last	Due to (or as a consec	quence of):						
8760,	cate be executed physician and the burial-transit	icai	d								
9	ntifica ng ph as th		IF FEMALE:						-		3-11-11-11
O. Box	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Med	23b. Was decedent pregnant in the past 12 months?	If yes, outcome of pregnation  1 □ Live birth 2 □ Feta  4 □ Pregnant at time of a  9 □ Unknown	al death 3	⊒Ectopic pregnanc □ Other (specify) _	ey .		2	3d. Date of de Month	livery Day Year
Δ.	s that ned b e deta	by Pł	Part II. Other significant conditions contrib	uting to death but not res	sulting in the u	inderlying cause gr	ven in Part I.	23e. Did	tobacco us	se contribute to	the cause of death?
rds	w require been sig should b	ed t	Chronic obstructive	e pulmon	ary d	isease		1	Yes 2	JNo 3 □Fi	robably 4 Unknown
ecords,	has bei ge 2 sho	Completed	Diabetes mellitu	\$				24a. Wa	s an opsy		utopsy findings available completion of cause of
$\alpha$	The late had page	E O	Coronary artery	Bease					formed?	death? 1 ☐ Yes	
Vital	ysician: The list certificate hadirector, page	Be (	25. Was case referred to medical examiner?					of Death (Check only	one)		
	£ 5 =	၉	1 ☐ Yes 2 ☐ No	1 Inpatient 21	ER/Outpatre	60 6671		sing Home 5 Res			cify)
Division of	E E	ion;	1 ⊟Natural 5 ☐ Pending	(Month, Day Year)	28b. Time o	Wo	nyat ork? ]Yes 2∐No	28d. Describe	a now injury	occurred	
Sic	Attending r death. ector: After you the fune	licat	2 Accident investigation 3 Suicide 6 Could not be	8e. Place of Injury - At h	ome, farm, st			28f. Location			ural Route Number,
≧		Certification;	4 Homicide determined	building, etc. (Speci		,		City or T	own, State)		
	To the Hospitel or Attendir within 24 hours after death.  To the Funerel Director: All completely filled in by the fu	edicai C	29a. Certifier 1 Certifying Physicia (Check only one) 2 Medical Examiner:	an: To the best of my knoon the basis of examination and manner stated.	owledge, deat ation and/or in	th occurred at the to estigation, in my	ime, date and opinion, death	place, and due to the occurred at the time	e cause(s) a e, date and	and manner as place, and due	s stated. e to the cause(s)
	To the within 2. To the Complet	Me	29b. Signature and title of certifier			29c. Licen	se number		29d. Date	e signed (Mont	th, Day, Year)
•			Rachel Hartu	an, MD		RES	5-000		Febr	uary	22, 2006
			30. Name and address of person who comp								
	A	urr		12n, MD 32. Sgistrar's Sign		rai Hos	pital	of Balt	arnor	٤	21215
	Sta Regist		31. Date filed (Month, Day, Year) FEB 2 7 2006	All Control of the Co	AL .	had.					
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DHMH 17 Rev 1/2001

Nancy Samis

Amend # 1 per Phy. 3-3-06 A.A.Co. Health Dept\_ PM Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene | | Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Philip Month Year **Physician** STRAUBINGER 2006 1726 PM 24 FERRUMALY /Medical Eacility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Taktymore //
If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Jan. 3, 5. Social Security Number 7. Ag (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min 1944 1₹M 2□ F Yrs. 62 Washington D.C. 215-42-0821 Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County item 27 is marked other than "netural", or Items 23a or 28a-f show other traumatic event, the Mactical Examinar must be notified at 1 ☐ Yes 2 No Annapolis Maryland Anne Arundel Direct 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21403 United States death 1 50 F by Funeral Sandstone Court 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 196 If Yes, Give Year or Dates: 197 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1964-1 Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: 1970 Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Account Facilitator Hospital 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Baynie Woods George W. Straubinger 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Odenton, Maryland 21113 Janet Reno / Personal Rep. 1312 Wickell Road 20a. Method of Disposition
1 □ Burial 2 ★ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Metro Crematory, Inc. 2/27/2006 ¹ 4 □Donation 5 □Other (Specify) Baltimore, Maryland 22. Name and Address of Facility John M. Taylor Funeral Home, Inc. 21. Signature of Funeral Service Licensee Mich 147 Duke of Gloucester St. Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) HYPOXEMIA Physician 5 Hours /Medical Due to (or as a consequence of): **Examiner** 3 mouths SMALL CELL LUNG Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner use as the burial-transit certificate be exec Due to (or as a consequence of): attending physician for use as the burial Division of Vital Records, P.O. Box 68760, Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4☐Pregnant at time of death 5 Other (specify) the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Yes 2 No 3 Probably 4 Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 2 No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No s after doc. ral Director: After ... by the funeral dr Đ Certification; To 1 Tes 1 npatient 2 ER/Outpatient 3 DOA 28c. Injury at Work? Date of Injury (Month, Day Year) 27. Manner of Doubt 28b. Time of 28d. Describe how injury occurred 1 XNatural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours a To the Funeral C 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie cal 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number RES-000 FEBRUARY 24, 2006 IND 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21287 NORTH WOLFE BALTAMORE, MARY LAND MATTHEW PIPFUNIL 600 32. Apgistrar's Signature 31. Date filed (Month, Day, Year) State Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** March 8, 2006 9:35 A /Medical Agnes Stachlik 4c. County of Death 4a, Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Anne Arundel Anne Arundel Medical Center Annapolis If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months 1 ☐ M 2 🔀 F New York 4-3-1922 Director 83 065-16-4644 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other then "netural", or Iteme 23e or 28e-1 ehow eny injury or other traumatic event, the Mudical Event. 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a State 1 ☐ Yes 2 X No Harwood Maryland Anne Arundel Director 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 20776 3716 Buffalo Court by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 MNo If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 □ Never Married 2 □ Married 1 ☐ Yes 2X No Specify Specify: 3 Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Retail Store Supervisor 12th 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Kowalinski Mary John Michalski ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3716 Buffalo Ct., Harwood, MD 20776 Marianne Zampardi/ Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 3-13-06 Long Island Natl. Cem. Pinelawn, New York 4 ☐Donation 5 ☐ Other (Specify) 21. Signatur & Mine | Service Licensee 22. Name and Address of Facility George P. Kalas Funeral Home Ull 2973 Solomons Island Rd. Edgewater, MD 21037 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, ause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-transit Due to (or as a consequence of) Box 68760. Be Completed by Physician/Medical attending p for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 110 Hospitel or Attending Physicien: director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ ₩ Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner 10 1 Natural 28b. Time of Injury 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 5 Pending investigation s after dec. 1 Yes 2 No 2 Accident within 24 hours are: \_\_\_\_ To the Funeral Director 6 Could not be determined 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 29a, Certifier tile certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ιO Annapolis MOZIYOI Ann our 31. Date filed (Month, Day, Year) 32 Registrar's Signature State MAR 1 4 2006 Registrar

			For State Registrar	State of M		d / Depa		of H	ealth a		ental Hyg		006	0781	
2 "	Physicia		1. Decedent's Name (First, Middle, Last								2. Date of Deat Month	Day	Year	3. Time of Dea	
	/Medic	al	Mark Roy Seas  4a. Facility Name (If not institution, give				4b. City. 1	Town, or	Location of		norch.	4c. Co	ZOO6 unty of Death	3.20	
	Examin	er	Washington County						rstow			I	Washing	ton	
4	Funeral Director		5. Social Security Number 6. Security Number 222–20–1390		9e (In yrs. Ia 79	ist birthday) Yrs.	If Under Months	1 Year Days	If Under 2 Hours	Min.	8. Date of Birth (Month, Day, Jan 8,	<sub>Year)</sub> L927		lace (State or Fo. try) 1D	reign
	and and		Usual Residence of Decedent  10a. State 10b. County		10c. City,	Town or Lo	cation						1	0d. Inside City Li	imits
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	h with the	al Director	10e. Street and Number 19807 Evelyn	Avenue			10f. Zip		742		1	0g. Citizer	of What Cour	stry? SA	
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other then "natural", or items 23s or 28s-f show way injury or other traumatic event, if a Medical Examinar must be notified at ance.	by Funeral	11. Marital Status  1 Never Married 2 Marned 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 Wyes 2 Il Yes, Give Year or Dates:	No No		Was Deced I Yes, spec		spanic Orig n, Mexican Specify:	gin? (Spe , Puerto F	cify Yes or No- lican, etc.)		Race - Americ Black, White, pecify: Whit	etc.	
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Baltimore, Maryland 21215-0036	should be filed withing and Mental Hygiene.  marked other ther umatic event, Ire.	To Be Co	17. Father's Name (First, Middle, Last) Byron Sease			rice	Harric				(First, Middle, M				
Mary	nd 2 shoulth and N 27 ie ma		19a. Informant's Name/Relationship (7 Helen E. Sease				-				Route Number				
more,	permit. Pages 1 and 2 Department of Health a Important; if item 27 is any injury or other tra		20a. Method of Disposition  1   ↑ Burial 2   ↑ Cremation 3   ↑ Donation 5   ↑ Other (Specify			ace of Disponentery, crembaugh					,2006 ]	zoc. Local Washi Frank	tion City or To ngton lin CO	wn State IWP PA	
Balti	permit. I Departm Importa any inju		21. Signature of Funeral Service Licens			22	. Name an	d Addres	s of Facility	Grov	re-Bower lynesbor	sox 1	Funeral	Home,	Inc.
760, <	Physician /Medical Examiner pe prijal-itansit	cal Examiner	23a. Part1. Ener the disease, or compshock, or heart lailure. List only disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Sop	tico a consequ a consequ	ence of):	er the mod	e of dying	g, such as	cardiac oi	respiratory arre	est,		Approximate Interval Between Onset and Deat	n th
P.O. Box 68	death certifica e attending ph ed for use as th	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Fetal	death 3	Ectopic pr Other (sp					230	d. Date of deliv- Month	ery Day Year	r
ds, P.	80 60	ρχ	Part II. Other significant conditions of	ontributing to death I	but not resu	lting in the u	nderlying c	ause give	en in Part I.		23e. Did tol		/	ne cause of death pably 4 □Unkr	
of Vital Records,	The ate h page	Completed									24a. Was a autops perform	ned?	prior to co death?	psy lindings avai mpletion of cause 2 116	ilable e of
Vita	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:				Othe	ar.		(Check only on				
on of	Phys this rai dii	tlon; To	1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Inj (Month, D		28b. Time o Injury		8c. Injun	4   140	2	ne 5 Reside 28d. Describe ho			(y)	
Division	if or Attending after death. Director: After d in by the fune	Certification;	3 Surcide 6 Could not be determined	28e. Place of In	ijury - At horitc. (Specify	me, farm, st	reet, lactory	, office		2	281. Location (Si City or Town		Number or Rur	al Route Number,	;
	To the Hospital or Atterviewithin 24 hours after de To the Funeral Directo completely filled in by the	Medical C	29a. Certifier (Check only one)  1 Certifying Ph 2 Medical Exam	ysician: To the besiner: On the basis and manner s	of examinat	wledge, deat ion and/or in	h occurred vestigation	at the tim , in my or	ne, date an pinion, dea	d place, a	and due to the cand at the time, d	ause(s) ar ate and pl	nd manner as s ace, and due t	tated. o the cause(s)	
	To th withir To th comp	×	29b. Signature and title of certifier	,				. License		٦			signed (Month,		
,	٨		30. Name and address of purion who	completed cause of	death (Item	23а) (Туре,	Print)	202	11 11	A	- ILAC	000	to 10/	706 MD217	16.5
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Pear February 22, 2006 **Physician** Irma R. Suarez 3:50 рм /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Holy Cross Hospital Silver Spring Montgomery 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Aug. 30, 1923 9. Birthplace (State or Foreign **Funeral** Months Min. 1 ☐ M 2 🗗 F Days Hours Bolivia 579-94-1956 Director 82 Yrs Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County ul Hygiene. other than "natural", or itama 23e or 28e-1 ahow vent, the Medical Examinar must be notified at 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Directo Maryland Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4701 Wissahican Avenue 20853 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. within 72 hours efter 1 □ Yes 2 🖾 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1<sup>™</sup>Yes 2□No Specify: Bolivian White Specify: Š 3 Nidowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home injury or other traumatic avent, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be fil ment of Heelth and Mental H lant: If Itam 27 ts marked ott Esequiel Suarez Mercedes Antelo 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Eva M. Zenteno/ Daughter 5115 Crossfield Court, Apt. 3, Rockville, MD 20852 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) February 25 permit. Page Depertment of Important: if any injuries once. Metropolitan Crematory 2006 Alexandria, Virginia 21. Signature of Funeral Service Licensee Francis Addess Collins Funeral Home Inc 500 University Blvd, W, Silver Spring, MD 20901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Sepsis /Medical Due to (or as a consequence of): Examiner Fever of Unknown Origin Sequentially list conditions, any, backing to introduct cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consecuence of) Examine ied by the ettending physician and deteched for use as the burial-transit law requires that the death certificate be executed Due to (or as a consequence of): of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>8</u> Renal Failure, Coagulopathy, Jaundice certificate hes been si rector, page 2 should 1 Yes 2 No 3 ☐ Probably 4 ☑Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 🗆 No Physician: To the Hospital or Attending Physician: within 24 hours efter death.

To the Funeral Director: After this certific completely filled in by the funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death Check only one Hospital: 1 Pinpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2X No 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Certification; 28c. Injury at Work? 28d. Describe how injury occurred Division 1 🖾 Natural 5 Pending investigation М 1 □ Yes 2 □ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide (E) Certifying Physicien: To the bast of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 15434 2-22-2006 o completed cause of death (Item 23a) (Type, Print) 30. Name and address of perso Neeraj Chopra, M.D. P.o. Box 83819, Gaithersburg, MD 20883 31. Date filed (Month, Day, Year) FEB 2 7 32 Fegistrar's Signature State 2006 Registrar

David L. Stull, Sr. Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 06-01277 State of Maryland / Department of Health and Mental Hygiene crn Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) Month **Physician** David L. Stull, Sr. 20 2006 February /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Frederick Frederick 6298 Linganore Road | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (St. Country) | Nov. 17, 1959 | Maryland 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) **Funeral** 1 XM 2 ☐ F 46 Yrs. 215-64-1929 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. Count r than "naturel", or lieme 23s or 28s-f ehor the Medical Examiner must be notified at 1 X Yes 2 □ No Directo Maryland Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 36 East 7th Street 21701 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 Yes 2 No Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Concrete Construction 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) . Pages 1 and 2 should be fil ment of Heelth and Mental H tent: if item 27 is marked off lury or other traumatic sven James E. Easterday Geraldine L. Mercer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1313 Motter Ave. Apt. 37, Frederick, MD 21701 Nicoal Rodriguez / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: if any injury or once. 2/27/2006 Libertytown, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Union Cemetery 22. Name and Address of Facility Stauffer Funeral Home, P.A. 21. Signature of Funeral Service License 1621 Opossumtown Pike, Frederick, MD 23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one call immediate Cause (Final disease or condition resulting in death) that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death Ple **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine anding physicien and use as the burial-transit or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) Box 68760. by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 4□Pregnant at time ol death 5 Other (specify) signed by the a 1 ☐ Yes 2 ☐ No Records, P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of e h? Z Yes 2 🗆 No 1X Yes 2 □ No of Vital To Be 25. Was case referred to medical 26. Place of Death | Check only one Other 4 Nursing Home 5 Residence 6 Hother (Specify) at scene Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1X Yes 2 □ No After thi 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of Medical Certification: Division 1 Natural 5 Pending Subject assaulted To the Funeral Director: All To the Funeral Director: All Found 2/20/06 1 Yes 2 No Found 7:45M investigation 2 Accident 6 Could not be determined 3 Suicide Location (Street and Number or Rural Route Number, Rd City or Town, State) 6298 Lin Sangre 28e. Place of Injury - At home, larm, street, lactory, office building, etc. (Specify) 4 Homicide Coustruction Site Found on Coustruction Site Fridirick Find

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

State

31. Date filed (Month Registrar

(Check only one)

29b. Signature and little of certifier

M3/ULCAH

30. Name and address of person who completed cause of death (Hem 23a) (Type, Print)

7 AB/UCAH AU 111 Penn Street, Baltimore, Maryland 21201 Registrar's Signature

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

February 20, 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State Registrar #5 & 17, 3/1/06, per/f.home Certificate of Death E.T. Amended item WCHD Reg. No: 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** 11:05 PM Dorothy Schafer 25 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Berlin
|| If Under 1 Year | If Under 24 Hrs. |
| Months | Days | Hours | Min. | Gull Creek Retirement Community Worcester 5. Social Security Number 217–18–2867 214–32–6769 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 1/10/1907 Birthplace (State or Foreign Country) **Funeral** Months 1 M 2 F 99 Director unknown Usual Residence of Decedent 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits other treumatic event, the Medical Examiner must be notified at 1 XYes 2 No Director MD Worcester Berlin 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ៰ or iteme 23a 1 Meadow St. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14 Race - American Indian Black, White, etc. within 72 hours after 1 Yes 2 No
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Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: þ Specify: White 3 XWidowed 4 ☐ Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b Kind of Business/Industry (Specify only highest grade completed) e filed within al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Owner/Operator Marina 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 1 end 2 should be fill Health and Mental H tem 27 ie marked ott Be Unknown Heler Unknown Heller ပ Unknown 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 le Charles Amos 163 Skipjack Lane, Swanton, MD 21561 permit. Pages 1 Department of He
Important: If item
eny injury or oth 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ₺ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □Donation 5 □ Other (Specify) Sunset Memorial Park 3/1/2006 Berlin, MD 21. Signature of Juneral Service Licenses 22. Name and Address of Facility 108 William St., Berlin, MD 21811 The Burbage Funeral Home

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician Thrive tailure 10 /Medical resulting in death) Due to (or as a consequence of): Examiner enenta ulars Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner ettending physicien and for use as the burial-transit death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Year Day 4 Pregnant at time of death 5 Other (specify) page 2 should be deteched 1 Yes 2 No 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed been: 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificete 1□ Yes 21 No 1 ☐ Yes 2 ☐ No funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Wother (Specify) 1 Yes 2 No Assisted Certification: To 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred After 1 Natural 5 Pending within 24 hours efter death. To the Funaral Director: A investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 9 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifie To the ! 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) (DE) C1-0006795 cu int Ke lotine Da 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MO KRISTINE M. 1209 COASTAC HIGHWAY, FENUICK ISLAND DE

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State

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31. Date filed (Month, Day, Year) FEB 2 8

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		For State Registrar	State of Maryl	•	artment of F rtificate of			iene g. No.	16	07816
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/Medica	al .	Michael	Roy	Tho	mpson	- I i I D II	Februar		2006 y of Death	7:10AM M
Examine	er	4a. Facility Name (If not institution, given Montgomery General Content of the Co			Olney	or Location of Death	1	Montg		
Funeral	~ X	5. Social Security Number 6.	Sex 7. Age (In	yrs. last birthday)	-	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Vearl	9. Birth	place (State or Foreign
Director		220 56 3173	1 <b>3</b> M 2 □ F 5	4 Yrs.	Months Days	Hours Will.	Nov. 24	,1951	Washi	ington, D.C.
and ow	-	Usual Residence of Decedent  10a. State 10b. County	100	. City, Town or Lo	cation					10d. Inside City Limits
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id be lental rked o	To Be	Roy B. Thompson				Frances	N. Bush			
should be many and he man		19a. Informant's Name/Relationship	(Type, Print)	19b. Mailir	ng Address (Street	and Number or Ru	ıral Route Number	City or Town	, State, Zi	p Code)
and and marter than the		Pamela Thompson 20a. Method of Disposition	/ Wife	1330 bb. Place of Dispo	Patuxent	Drive As		ryland		0861
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Deartill Dages Department of mportant: If it any injury or once.		4 □Donation 5 □ Other (Special Signature of Funeral Service Lice			Mem Park  2. Name and Addre	ess of Facility <b>Hir</b>	•		-	
		+ out	News							g, MD 20904
		23a. Part1. Enter the disease, or con shock, or heart failure. List only	pplications that caused the one cause on each line.	death. Do not ent	er the mode of dyi	ng, such as cardiac	or respiratory arm	est,		Approximate Interval Between
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To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	edicai	29a. Certifier (Check only one)  Certifying P  Certifying P	hysician: To the best of my miner: On the basis of exa and manner stated.	knowledge, deat mination and/or in	h occurred at the ti vestigation, in my	me, date and place opinion, death occu	e, and due to the ca arred at the time, d	ause(s) and nate and place	nanner as , and due	stated. to the cause(s)
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25		1 Star	WIS W	SIM		39190	Fe	bruary	, 22,	2006
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Registra		FEB 28	2006 Janua	, B. B	parte					

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	Physici	200	1. Decedent's Name (First, Middle, L.	ast)						:	<ol><li>Date of Dea Month</li></ol>	th Day	Year	3. Time of Death
	/Medic			nie Debr		nornton					March		2006	0400 A <sup>M</sup>
	Examir	er	4a. Facility Name (If not institution, gi		ımber)		4b. City, To						inty of Death	
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	Director	}	214-74-6445 Usual Residence of Decedent		50						April 9,	1955_	<u> </u>	rginia
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lan	id be lental ked ic ev	To B	Jeff Yates						Wi1	lie (	Charles			
Maryland	shou ind N mar umat		19a. Informant's Name/Relationship	(Type, Print)		19b. Ma	ling Address (S	treet a					wn, State, Z	ip Code)
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Division of Vital	or At offer of Direction by	Certification;	4 Homicide determine	4 28e. Piac	ding, etc.	ry - At ho <i>m</i> e, farm, : . <i>(Specify)</i>	street, factory, o	TICE		2	City or Tow		mber or Hu	ral Route Number,
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu		29a. Certifier 1 Certifying F	Physician: To th	a bact o	f my knowledge, de	ath occurred at I	the time	e date an	d place, as	nd due to the o	auco(c) and	l manner as	etated
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	à		30. Name and address of person wh	. •			e, Print)						-	
	6		Helen Noble, M.D	., 122	Spee	r Road, S	Suite 5,	,_Cl	este	rtown	, MD 2	1620		
	Sta		31. Date filed (Month, Day, Year)	32	Registra	r's Signature	andel							
	Regist	ar	MAR 1 4 7	2006	ELAS.	1 15 19								

State of Maryland / Department of Health and Mental Hygiene [] Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day **Physician** 25<u>,</u> QUE TRUONG FEB. 2006 8:00 A /Medical 4c. County of Deeth 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner MONTGOMERY 527 INDIAN SPRING DR. SILVER SPRING Ε. If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 ☐ M 2 💢 F Yrs VIETNAM 78 27,1927 **Director** 212-31-5350 Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location irel", or items 23e or 28e-f show LExemples must be notified at 1 Yes 2 No Directo MONTGOMERY SILVER SPRING MD. 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20901 U.S.A. INDIAN SPRING DR. Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item any injury or other traumatic event, the Medical Example and note. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: þ 3 Widowed 4 Divorced ASIAN Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 HOMEMAKER HOME 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be TRUONG **OUA** TRAN THANH 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) QUE CHI T. LAM/DAUGHTER 527 E. INDIAN SPRING DR., SILVER SPRING, MD.20901 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Slate 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) CHAMBERS CREMATORY | 2-28-2006 RIVERDALE, MD. 22. Name and Address of Facility CHAMBERS FUNERAL HOME & CREMATORIUM, P. A. 21. Signature of Fuperal Service Licensee M Chambus M00091 5801 CLEVELAND AVE., RIVERDALE, MD. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician LUNG CANCER 18 MONTHS disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed Due to (or as a consequence of): attending physician a for use as the burial Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 XNo has le 2 page this certificate 1 Yes To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 Inpalient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes Certification: To **X**□ No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After XNatural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide within 24 hours a 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2 D43083 FEB. 27, 2006 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SOTOS, M.D. 9707 MEDICAL CENTER DR., #300, ROCKVILLE, MD. 20850 GEORGE A. 31. Date filed (Month, Day, Year) 32. Registrar's Signature donne State Registrar

DHMH 17 Rev 1/2001

		•	For State Registrar	State of I	Maryland		artment of rtificate of				giene	6	078	19
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	/Medic		Ray Earle	Tucker						Februa	ary 22,2		6:45	<i>A</i> <sup>M</sup>
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	Funeral				Age (In yrs. Ia	ist birthday)	If Under 1 Yea	r If Unde	_	8. Date of Birt			place (State ontry)	or Foreign
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	28a-f	Director	10e. Street and Number	I L		iesupe	10f. Zip Code				10g. Citizen of V	What Cou	ntry?	
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	death	Funeral	11. Marital Status	12. Was Decede	e?	i. 13.	Was Decedent of If Yes, specify Cu	Hispanic O	rigin? (Spe	ecify Yes or No-	- 14. Rac	e - Americ	can Indian,	
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		í	For State Registrar	State of M	aryland		artment o			and M		glene leg. No. 0 (	16	07820
			Decedent's Name (First, Middle,	Last)							2. Date of Dea	ith		3. Time of Death
	Physici /Medio		Dorothy Fra	nces Tyle:	r						Month Februa	rv 24	<sup>Yθαr</sup> 2006	1:15 p <sup>M</sup>
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			Mallard Bay Care	e Center			Can	bri	ıdge			Do	er	
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	show	_	10a. State 10b. County	,	10c. City,	, Town or Lo							1	0d. Inside City Limits
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of	hys this al dir	e,	1 ☐ Yes 2 🖼 Ro	Hospital: 1 Inpat		R/Outpatien					ne 5 🗆 Reside			)
n c	After uner	on:	27. Manner of Death  1 Natural 5 Pending	28a. Date of Inj (Month, Da	ay Year)	28b. Time of Injury		Work?	? _		28d. Describe ho	ow injury occu	irred	
Sic	tend leath tor: / the f	cat	2 Accident investigat 3 Suicide 6 Could no	t he			М		es 2□N					
Division	el or Attending P s efter death. Il Diractor: After i d in by the funera	Certification:	4 Homicide determine	286. Place of In	njury - At hon etc. <i>(Specify)</i>	ne, tarm, stre	eet, factory, of	fice		1 2	28f. Location (Si City or Town		iber or Rural	I Route Number,
	urs e		5-2-11							1				
	To the Hospitel or Atte within 24 hours efter de To the Funeral Directo completely filled in by th	edical	29a. Certifier Check only one) 2 Medical Ex	Physician: To the besi aminer: On the basis	ot examination	rledge, death on and/or inv	occurred at the stigation, in	he time my opi	e, date and nion, deat	d place, a h occurre	and due to the cast ad at the time, d	ause(s) and n ate and place	nanner as sta , and due to	ated. the cause(s)
	To tha l within 2. To tha I complet	Mec	29b. Signature and title of certifier	and manner s	tated.		29c 1i	cense	number	_	2	9d. Date sign	nd /Month (	Day Vaas
	₹ <u>8</u> 5		255. Organization and title of Certifier	loy MD			1		920		2	2 · 2		
,			Jave	1				-1/	100	1		1. 1	-1 0	5.0
			30. Name and address of person who NOM AN TITAL	wy 300	death (Item :	23a) (Type, Re) RA	Print)	C	AMM/	211)	GE .	70 2	-161	3
	Sta Registr	_	31. Date filed (Month, Pay, Year)	2006 32 Regist	trar's Signatu	are en					GE .			

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Registrar

28 2006

			1 - For State Ragistrar		State	of Maryla	nd / Depa	artmen rtificat					Reg	ene)	06	0782	2.2
Ph	ysicia	ภา	Decedent's Name (First, Midd.	le, Last)			_					2. Date of Month		Day	Year	3. Time of	
//	Nedic	al	Sarah		H			Vines	T			Febru	ary	21	2006	9:20	a <sup>M</sup>
Ex	amin	er	4a. Facility Name (If not institutio							Location o	or Death				County of Death  Anne Arundel		
Fun	oral		Chesapeake H  5. Social Security Number	6. Sex	ce no		s. last birthday)	Linthicum  rthday) If Under 1 Year   If Under 24 Hrs					f Birth		9. Birtholace (State or I		
Dire			578-36-1372	1 🗆	M 2₹F	93	Yrs.	Months	Days	Hours	Min.	Jan.	9,	1913	Ala	abama	. 3
P ,			Usual Residence of Decedent			100.0	N. T.						-				
aryla <b>sho</b> v	15 at	5	10a. State 10b. County		1 1		City, Town or Lo									10d. Inside Ci	
the M	otitle	Director	MD Anne  10e. Street and Number	Arur	ideT		Edgewat	er 10f. Zip	Code				10	Citiena	of What Cou	1 🗆 Yes	XX
with o	3	2	1715 Millstone	nri	77.0			TOI. ZIP		.037			100		SA	mtry :	
Jeath ms 23	TOWN	Funeral	11. Marital Status		2. Was Dec	edent Ever in	U.S. 13.	Was Deced			gin? (Sp	ecify Yes o	r No-		SA Race - Ameri	can Indian,	
or life or	Till I	교	1 Never Married 2 Mar	ried	Armed F	2 XXio					i, Puerto	Rican, etc.	.)		Black, White		
ours a	Era	å by	3XXVidowed 4 ☐ Divorced	1	If Yes, Gi Year or D	ve Dates:		1 ☐ Yes	XXXVo	Specify:				Spe	c <i>ify:</i> [/	Thite	
72 h	diga	Completed	15. Deceder (Specify only highe	nt's Educ	ation completed)		(Give	dent's Usua kind of wor	rk done d	during mos	t of work	ing	16	6b. Kind of	Business/Ir	ndustry	
Aithin Fe	N W	m m	Elementary/Secondary (0-12)		College (	1-4or 5+)	Cler	DO NOT us •1=	ie retirea	)				modf:	t Bure		
filed Hygie	nt,	မ င်	12 17. Father's Name (First, Middle,	Last)			OTEL	K.		18. Mothe	r's Name	e (First, Mic				au	
Id be sontail	C	To B	Riley L. Hende	ersor	1							ammon			•		
shound M	umat	-	19a. Informant's Name/Relations				19b. Maili	ng Address	(Street a					City or Tov	vn, State, Zi	p Code)	
alth a	ertra		James P. Vines	s (Sc	n)		171	5 Mil	1sto	ne Di	cive	, Edge	ewat	er, 1	MD 210	37	
of He	to th		20a. Method of Disposition 1 □ Burial 2X Cremation	2 DD	mount from		Place of Dispo cemetery, crei	osition (Nan	ne of ther place	θ)	-	Date	20	c. Locatio	on - City or T	own, State	
Pag ment	ury o		4 Donation 5 Other (S		movai iroin	1	etro Cr	emato	ry	1 2	2-23-	-2006		Balt:	imore,	MD	
Datumore, Mary Jiano 2 12.13-0000 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23e or 28e-1 show	eny in		21. Signature of Funeral Service	License	1.11	1	22	2. Name an Harde				Home,	P /	1			
9 002	# Q		23a. Part1. Enter the disse, o	U.	wa	<b>t</b>	ath Daniel	12 Ri	dge	Ly Av	enue	, Ann	apo]	lis,	MD 21	401 Approximate	
Physic /Med Exami	ical iner	iner	shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	a.	Due to			roky	Dis	O ASK					LON	Interval Bett Onset and I GSIANDI	Death
ifficate be executed g physicien and	the bur	ledicai Examiner	Cause (Disease of Injury that initiated events resulting in death) Last	C.	Due to	(or as a conse	equence of):										
To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death.	sched for use	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 gronths? 1 ☐ Yes 2 No 9 ☐ Unknown	23	1 ☐ Live I	tcome of pregibirth 2 Fe nant at time of nown	tal death 3[	Ectopic pr Other (sp					_		Date of deliv Month	-	fear
v requires that	should be deta	2	Part II. Other significant conditi	ons cont	ributing to d	leath but not re	esulting in the u	nderlying c	ause give	en in Part I.				cco use co 2 □ No		the cause of d	leath? Inknown
i: The law	, page 2 sl	Completed										a	Was an utopsy performe as 2)	1.	b. Were auto prior to co death? 1 \( \text{Yes}	opsy findings a empletion of ca 2 No	available ause of
liciar	recto	Be	25. Was case referred to medica examiner?		spital:				Othe			h (Check o		1/		1) =	1
F F Sile	ra d	2	1 Yes 2 No 27. Manner of Death		1 ∐ 28a. Date	of Injury	ER/Outpatier 28b. Time o		A	4 🗆 Nu		me 5 🗆 F 28d. Descr			Other (Speci curred	M) HO>	PICE
Thirding :	e fune	ıtlo	1 Natural 5 ☐ Pendir 2 ☐ Accident investi	ng gation	(Mor	ith, Day Year)	Injury	м	Bc. Injury Work 1 □ \	(? Yes 2 🔲 I							
To the Hospital or Attending F within 24 hours after death. To the Funeral Director: After	completely filled in by the funeral director, page 2	Certification:	3 Suicide 6 Could 4 Homicide determ		28e. Płace build	e of Injury - At ing, etc. (Spec	home, farm, str	reet, factory	, office			28f. Location City or	on (Stre Town,	et and Nui State)	mber or Run	al Route Numi	ber,
the Hospi in 24 hou the Funer	pletely fill	edical	(Check only 2{ Medical one)	Examin	er: On the b	e best of my kr easis of examin ner stated.	nowledge, deat nation and/or in	vestigation,	in my op	pinion, dea	d place, th occurr	and due to red at the ti	the cau me, date	se(s) and and place	manner as se, and due t	stated. o the cause(s)	)
T W	000	Σ	29b. Signature and title of certifie	P	ras of			290	License	number	9		290	Date sign	ned (Month,	Day, Year)	
				0					V 5	2	/			72:	2/08		
				EEF	E ME	> 20		Print),	-PXX	Lway	· S	VITE	#10	OA	MAPO	ers M	0
	Stat	е	31. Date filed (Month, Day, Year,	2006	37	Registrar's Sign	nature	- 10 -							2	2140	1

			For State Registrar	State of Ma	aryland	-			lealth and Death	Mental	Hygien	21111	6	07823
	Bhysia	ion	1. Decedent's Name (First, Middle, La	_						2. Date of Death Month Day Year				
	Physici /Medi	cal	NORMA	VESTA						FEBURALY 23, 2006 9;				
	Examir	ner	4a. Facility Name (If not institution, give BALLIMORE WAS	re street and number)	Dedic	A/	4b. City	, Town, or	Location of Dea		4	County of	f Death	2000
-	Funeral		Social Security Number     6. 8		(In yrs. last	birthday)		er 1 Year	If Under 24 H	s. 8. Date	of Birth	INN	9. Birthp	TKUDAC) lace (State or Foreign try)
	Director		210-12-9703	1□M 2XVF	81	Yrs.	Months	Days	Hours Mi	Aug.	4, 19	924	Iow	a
	land ow		Usual Residence of Decedent  10a. State 10b. County		10c. City, T	own or Lo	cation						1	0d. Inside City Limits
	n the Maryland r 28a-f ehow	to	MD Anne Ar	unde1	Pasa	idena								1 ☐ Yes 2 No
	or 284	Olrec	10e. Street and Number				10f, Z	ip Code			10g. C	itizen of W	hat Coun	try?
4	s 23a	rail	7726 Pine Haven					2112				USA		
500	within 72 hours after death with the Maryland sne. sne. than "natural, or items 23a or 28a-f ehow he Mcdical Examinat must be notified at	Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent E Armed Forces? 1 ☐ Yes 2√√√0					spanic Origin? ( n, Mexican, Pue	Specify Yes into Rican, et	or No-		- Americ , White,	an Indian, etc.
036	ours a ral', o	þ	3 <b>X</b> Widowed 4 □ Divorced	1 □ Yes 2777 If Yes, Give Year or Dates:		1	I □ Yes	2XXN0	Specify:			Specify:	Wh:	ite
5-6	"natu	Completed	15. Decedent's E (Specify only highest gra	ducation ade com <i>pleted)</i>	1	6a. Deced	kind of w	ork done o	luring most of w	orking	16b. I	Kind of Bus	iness/Inc	dustry
₹25	withir lene. then	dmo	Elementary/Secondary (0-12)	College (1-4or 5-	+)	Lega		<sub>use retired</sub> creta			La	a w		
字	e filed al Hyg other	Be C	17. Father's Name (First, Middle, Last	)					18. Mother's N	ame (First, M			)	
Na Na	2 should be filed v and Mental Hygie I'ls marked other traumatic event, Ih	To	Frederick T. Fal	1an					Goldie	Mae V	latkin	s		
Tap	s 1 and 2 should be filed within 72 hours after death with F Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or other traumatic event, the Medical Examinal must be		19a. Informant's Name/Relationship (						ind Number or F			or Town, S	tate, Zip	Code)
i S. j	Health Health tem 27		Linda Britt (Dau 20a. Method of Disposition		20b. Plac	P.U. e of Dispo- etery, cren			Lothia	n, MD	-	ocation - C	ity or To	wn. State
$\sqrt{ES}$ altimore	Pages lent of nt: if if		1 ØBurial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif			etery, cren lfiel				7-2006		Lesvi		
	permit. Pages 1 and 2 Department of Health a Important: if Itam 27 is any Injury or other tra once.		21. Signature of Funeral Service Lies						s of Facility Funera		-		,	TID .
m m	89658	Ш	23a. Part1. Enter the disease, or com	y-			12	Ridge	<u>ly Aven</u>	ue, An	napoli	s, M	214	401
8760,	Physician /Medical Examiner properties of the prijel-transit prope	dical Examiner	shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially flat conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or as a c. Due to (or as a	ACU consequen CF2 consequen		M10	10CI	untel	HCC	JEAN JEN	LCT.		Approximate Interval Between Onset and Death
9	ate:	edic		_ d										
Вох	Physician: The law requires that the death certific this certificate has been signed by the attending praid director, page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at t 9 □ Unknown	2 ☐ Fetal de	ath 3 🗆	Ectopic p Other (s	pecify)			-	23d. Date Mont		ry Day Year
Division of Vital Records, P.O.	quires thai in signed t	ρ	Part II. Other significant conditions of	ontributing to death bu	t not resultin	g in the un	derlying	cause give	n in Part I.		Did tobacco 1 □ Yes 2			e cause of death?
ဝ၁	law requir as been si 2 should	Completed	5								Was an	24b. W	ere autop	sy findings available
Ä	The I	E C					_				autopsy performed? 'es 2 No	de 1	or to com ath? ]Yes	sy findings available apletion of cause of 20 No
/ita	ysician: Th is certificate director, pag	Be	25. Was case referred to medical examiner?	Manadal.					26. Place of De					
of	Phys r this ral dir	٦.	1 Yes 2 No  27. Manner of Death	Hospital: 1 Inpatien		Outpatient			4 🗀 Nursing		Residence			)
<u>io</u>	Attanding Ph r death. sctor: After thing the funeral	ation	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day	Year)	Injury	м	28c. Injury Work 1 □ \	? ′es 2 □ No	200. 5630	nos nos miju	ily occurred	•	
Divis	i Dir	Certification;	3 Suicide 6 Could not by determined	28e. Place of Injurbuilding, etc.	ry - At home (Specify)	, larm, stre	eet, lactor	y, office			ion (Street ai r Town, State		or Rural	Route Number,
	the Hospitel hin 24 hours the Eunerel I the Funerel I	edical	29a. Certifier 1 ✓ Certifying Ph (Check only one) 1 ✓ Certifying Ph	ysician: To the best of niner: On the basis of and manner stat	examination	dge, death and/or inv	occurred estigation	at the tim	e, date and place inion, death occ	e, and due to turred at the t	the cause(s ime, date an	and manr d place, an	ner as sta d due to	ited. the cause(s)
	To the to the comp	Z	29b. Signature and title of certifier				29	c. License				ite signed (		
			, i sech	_				1)00	05578	23	FEE	BULAT	L4 2	23, 2006
			30. Name an dress of person who BATT IN OILE WI					للارح	TR.	6.3	S W i	1 1155	.1.	23, 2006 11)
	Sta	te	31. Date filed (Month, Day, Year)	32. Registra			200			GLE	_5u"		,,	
	Registr	ar	FEB 2 7 3	2006		4	6							

			1 - For State Registrar	State o	f Marylar			nt of He		and Me	ental Hy	gien Reg. N	HIII	0	78	24	
			1. Decedent's Name (First, Middle, Last)								2. Date of De Month	eath Da	ay Yea	1 -	3. Time o	f Death	
	Physici /Medio		SOPHIE	WACHT	LER					]	FEBRUARY	24,	2006		:35	АМ	
7	Examir		4a. Facility Name (If not institution, give s	street and nui	mber)		4b. Cit	y, Town, or Lo	ocation o	f Death		4	c. County of De	ath			
			8100 CONNECTICUT AVENU	E #816			CHEV	Y CHASE				M	ONTGOMERY	ľ			
	Funeral		5. Social Security Number 6. Sex		7. Age (In yrs.	last birthday)	If Unc		f Under a	24 Hrs. Min.	8. Date of Bi (Month, Da	rth av. Year	th y, Year)  9. Birthplace (State or F Country)				
	Director		114-26-8835	M 20X1F		85 Yrs.	World	Days	110013		1920	GEI	RMANY				
	P .		Usual Residence of Decedent		40- 01	T								104	Innida O	the distant	
	aryta hov	L.	10a. State 10b. County		10c. Ci	ty, Town or Lo	cation									ity Limits	
	Ba-f	cto	MARYLAND MONTGOMERY		CHE	VY CHASE											
	ith th	Director	10e. Street and Number				10f. 2	ip Code					itizen of What (	Country?	?		
	23 ath w		8100 CONNECTICUT AVENU				1	20815					.S.A.				
	te m	Funeral	11. Walter States	Armed Fo		.S. 13. \	Nas Dec f Yes, sp	edent of Hisp secify Cuban,	anic Orig Mexican	gin? (Spec , Puerto F	cify Yes or No Rican, etc.)	0-	14. Race - An Black, Wh				
36	or i	by Fi	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 🖾 Divorced	1 ∐Yes If Yes, Giv	/8		1 🗆 Yes	2 🛛 No .	Specify:				Specify: L	HITE			
ë	ural'	D D		Year or D	ates:	16a Dagge	iont's Lie	sual Occupation	00			165	Kind of Busines		ha.		
ည်	within 72 hours after death with the Maryland ene. than "natural", or items 23e or 28e-f ehow he Madical Exarte ar must be notified at	Completed	15. Decedent's Edu (Specify only highest grade			(Give	kind of v	vork done dur use retired)	ing most	of workin	g	100.1	KING OF BUSINES	Syllidusi	ıry		
7	within and the Man	Ĕ	Elementary/Secondary (0-12)	College (1	1-4or 5+)	SECRETA		,				AME	RICAN CA	NCER	SOCIE	ETY	
2	Hygin Hygin		12 17. Father's Name (First, Middle, Last)			DEOIGSEZ		18	8. Mothe	r's Name	(First, Middle						
Maryland 21215-0036	d be antal	o Be	COL OMON	DIENS	STOC				AMELI	Α		ST	ROH				
2	mark	5	SOLOMON  19a. Informant's Name/Relationship (Ty)		3100	19b. Mailir	a Addre				Route Numb	er, City	or Town, State	Zip Co	de)		
<u>8</u>	d 2 s		DINA GRUBER/NIECE				•	•					ND 20895				
ģ	Heal Street		20a. Method of Disposition	· · · · · · · · · · · · · · · · · · ·	20b. F	Place of Dispo	sition (A	ame of	1		ate		Location - City of	r Town,	State		
ᅙ	nt of its		1 🖾 Burial 2 Cremation 3 🗆 R	emoval from	State	cemetery, cren			10.3	2/26/2	006	ADEI	PHI, MAR	YT.AND	)		
altimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural; or Items 23s or 28s-1 show any injury or other traumatic event, the Maritsal Examinant and notice.		4 □Donation 5 □ Other (Specify)  21. Signature of Funeral Service License	90 /	MI.	LEBANON					000	ADEL	11111, 11111t	1 121112			
Ba	Departiment of the particular		) annudas	Puda	22. Name and Address of Facility HINES-RINALDI FUNERAL HOME, INC. 11800 NEW HAMPSHIRE AVENUE, SILVER SPRIN									A RVT. A	ND 20	1904	
	_		23a. Part1. Enter the disease, of compli	cations that o	aused the deat								of KING, IL	Ap	proximal	te	
			shock, or heart failure. List only or Immediate Cause (Final	ne cause on e	ach line.						,				erval Bet iset and		
	Physician /Medical		disease or condition resulting in death)	ALS													
	Examiner				(or as a consec												
		er	Sequentially list conditions,		INSUFFIC									-			
	ted nsit	ulu	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		CENSION	, , -											
	xecu and al-tra	Examin	that initiated events resulting in death) Last		or as a conseq	uence of):											
8760	icate be executed physician and s the burial-transit			1													
687	icate phys s the	dical															
	certil Iding Ise a	/We	IF FEMALE: 23b. Was decedent pregnant 2		come of pregna								23d. Date of d	eliverv			
Вох	atter	clar	in the past 12 months?		ointh 2 Feta eant at time of c		Ectopic Other (	pregnancy specify)					Month	Day	у ,	Year	
o.	that the deeth certific ed by the attending p detached for use as	ıysi	1 Yes 2 No 9 Unknown	9□ Unkn	own	-0.0											
<u> </u>	res that signed b be deta	F P	Part II. Other significant conditions cor	tributing to de	eath but not res	sulting in the ur	nderlying	cause given	in Part I.		23e. Did	tobacco	use contribute	to the ca	ause of c	death?	
g	uires n sigr	D D									1 🗆	Yes 2	2 □ No 3 □ I	robably	4 🖄	Unknown	
Ö	w require been si should I	ete									24a. Was	an	24b. Were	autopsv	findings	available	
Records,	The law requires that the deeth certific te has been signed by the attending is age 2 should be detached for use as	Completed by Physiclan/Me										ormed?	prior to death?	comple	etion of c	ause of	
_		e Co	25. Was case referred to medical						ie Diace	of Dooth	1 Yes	2[XN	o 1 🗆 Ye	s 2	J No		
Vital	Physiclan: this certific ral director,	<b>20</b>	eyaminer?	lospital:	Inpatient 2	EB/Outpation	t 3□ i				(Check only		6 ☐Other (Sp				
ō	를 을 들	.: To	27. Manner of Death	28a. Date	of Injury	28b. Time of		28c. Injury at			8d. Describe			ecity)			
o	tending Ph leath. lor: After th the funeral	tlor	1 XXNatural 5 ☐ Pending 2 ☐ Accident investigation	(Mon	th, Day Year)	Injury	М	Work? 1 ☐ Yes	s 2 🗆 î	No							
Division of	or Attending after death. Director: After in by the fune	flca	3 ☐ Suicide 6 ☐ Could not be		of Injury - At h		eet, fact	ory, office		2			ind Number or I	Rural Ro	oute Num	ber.	
	after after Direction by din b	Certification;	4 Homicide	buildi	ng, etc. (Specia	fy)					City or To	wn, Stai	fe)				
	To the Hospital or At within 24 hours after d To the Funeral Direct completely filled in by		29a. Certifier 1 \(\bar{\text{\tint{\text{\tint{\text{\tert{\text{\text{\text{\ti}\text{\texi}\text{\text{\texi}\text{\text{\text{\texi}\text{\text{\text{\texi}\text{\text{\texitil}}}\text{\text{\text{\text{\texit{\texit{\texi{\text{\text{\text{\														
	n 24   n 24   ne Fu	edical	(Check only 2 Medical Examinations)		asis of examina per stated.	ation and/or inv	estigati	on, in my opini	ion, deat	th occurre	occurred at the time, date and place, and due				cause(s	÷)	
	withir To the	Me	29b. Signature and title of certifier	_ /		10	2	9c. License n	umber			29d. Da	ate signed (Moi	nth, Day	, Year)		
	0		111	Well.	lu 1	4	>	28813				ומסקק	UARY 24,	2006			
	1		30. Name and address of person who co	mpleted caus	se of death (Her	11 23a) (Type,						PEDK	UMRI Z4,	2000			
			TRA TAUBER, M.D., 10					PRING, M	ARYLA	ND 209	902						
	Sta	te	31. Date filed (Month, Day, Year)	32 P	egistrar's Signa	ature	- 00	i							·		
	Registr		FEB 2 8 20	U6	Bates &	J. Sape											

			1 - For State Registrar	State of Mary	· ·	artment of rtificate of			giene 005	07825
	Physici	an	Decedent's Name (First, Middle, L.					2. Date of Dea Month	ath Day Yea	3. Time of Death
	/Medic		MARGARET KONY		S			Februar	y 22 200	6 6:35 P M
	Examin	er	4a. Facility Name (If not institution, g				or Location of I	Death	4c. County of D	
			Brooke Grove Ref		Home	Olney If Under 1 Yea		Hrs. 8 Date of Birt	Montgo	
	Funeral Director		577.29.4861	1□M 2♥F 81	Yrs. last billiday)	Months Day		Min. 8. Date of Birt (Month, Da)	y, Year)	Birthplace (State or Foreign Country) erra Leone, WA
			Usuel Residence of Decedent			<u> </u>			1924 31	erra Leone, wa
	rylan show	_	10a. State 10b. County	10	c. City, Town or Lo	ocation				10d. Inside City Limits
	Ba-f s	50	Maryland Montgon	nery	Rockvi					1 ∑ Yes 2 ☐ No
	with th	Funeral Directo	10e. Street and Number			10f. Zip Code		/	10g. Citizen of What	Country?
	eath v	erai	14705 Waterway I	12. Was Decedent Eve	rin II C 13	20853		2 (Specify Ves or No	U.S.A.	merican Indian,
	fter d	Fun	1 ☐ Never Married 2 ☐ Married	Armed Forces?				n? (Specify Yes or No- Puerto Rican, etc.)	Black, W	
036	ursal al', ol	by	3 ☑ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 □ Yes 21 N	o Specify:		Specify: B	lack
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or Itema 23a or 28a-f show he Madical Ezaitë ar nast tee notified at	Completed	15. Decedent's (Specify only highest g		16a. Dece	dent's Usual Occi	upation	f warking	16b. Kind of Busine	ss/Industry
7	ifthin and a second	npie	Elementary/Secondary (0-12)	College (1-4or 5+)		kind of work don DO NOT use retii			Domesti	
7	Hygien Hygien other th	S	12th 17. Father's Name (First, Middle, Las	et)	1	Ousewile		Name (First, Middle,		
anc	ould be f Mental It arked of atic ever	Be	Jubanga Sandy	si/			Marth		Maideri Sullanie)	
Maryland	should Ind Meni	ဥ	19a. Informant's Name/Relationship	(Type, Print)	19b. Maili	ng Address (Stree		or Rural Route Numbe	er, City or Town, State	e, Zip Code)
Z	and 2 : ealth ar n 27 is nar trau		Wanda W. Songa/					e, Rockvil		
re,	s 1 a of Hear		20a. Method of Disposition		Ob. Place of Disno			Date	20c. Location - City	
altimore,	Pages nent of h ant: if its		1 ☑ Burial 2 ☐ Cremation 3 `4 ☐ Donation 5 ☐ Other (Spec	Removal from State				/11/2006	Silver Sp:	ring, MD
alti	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Department of Hall and Mental Hygiene. The Maryland of Health and Mental Hygiene. Department of Hall hall hygiene. Department of Hygiene. Department of Hygiene. Department of Hygiene.		21. Signature of Funeral Service Lic	ensee	. H	Name and Add	ress of Facility	NERAL HOME	TNC	
8	8 9 E 2 9		Namy A.	Vean	ا ا	.800 New	Hampsh:	ire Ave, S	ilver Spr	ing, MD 20904
			23a. Part1. Enter the dispase, or co shock, or heart failule. List on	mplications that caused the ly one cause on each line.	deeth. Do not ent	er the mode of dy	ying, such as ca	rdiac or respiratory ar	rest,	Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	a. CHEONI	U OBSTI	WORK	poume	May 125	EDE	YEAR (
	/Medical Examiner		resulting in dealing	Due to (or as a co	onsequence of):					1.15
		ē	Sequentially list conditions if any, leading to immediate	Due to (or as a co	onsequence of):					
	uted d ansit	E I	f any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events							
ó	exec an an rial-tr	Exa	resulting in death) Last	Due to (or as a co	nsequence of):					
8760,	death certificate be executed e attending physician and ad for use as the burial-transit	Physician/Medical Examiner		d						
39	death certifica attending ph d for use as th	Med	IF FEMALE:							
Вох	ath ce	ian/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of p	Fetal death 3	Ectopic pregnan	су		23d. Date of Month	delivery Day Year
P. O.	the a	ysic	1 ☐ Yes 2 No 9 ☐ Unknown	4□Pregnant at time 9□ Unknown	e of death 5L	Other (specify)				,
	law requires that the de as been signed by the 2 should be detached	/ Ph	Part II. Other significant conditions	contributing to death but ne	ot resulting in the u	nderlying cause g	jiven in Part I.	23e. Did to	bacco use contribute	to the cause of death?
ds	w requires that been signed t should be det	d by	DEMENTA					1 🗆 Y	es 2 No 3 □	Probably 4 Unknown
COI	w req	iete						24a. Was a	an 24b. Were	autopsy findings available
Vital Records,	The lay	Completed		**					rmed? death	
ita	iician: Th certificate rector, pag	a)	25. Was case referred to medical				26. Place of	Death (Check only of		93 213410
	Physician: rthis certific ral director,	To B	examiner? 1 ☐ Yes 2 <b>∑</b> No	Hospital: 1   Inpatient	2 ER/Outpatier	nt 3□ DOA O	ther: 4 Nursi	ing Home 5 🗆 Resid	lence 6 Other (S	pecify)
0	ding Phy J. After thi funeral o	ü	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Ye	28b. Time o	28c. Inj	ury at ork?	28d. Describe h	now injury occurred	
sio	Attending r death. actor: After by the fune	cati	2 Accident investigati 3 Suicide 6 Could not	be			]Yes 2∏No			
Division of	I or Attendate death Director:	Certification:	4 Homicide determine	28e. Place of Injury - building, etc. (S		eet, factory, office	Ð	28f. Location (S City or Tow		Rural Route Number,
	ours a		29a. Certifier LX Certifying F	Physician: To the best of m	v knowledge deati	occurred at the	time date and r	place, and due to the o	rause(s) and manner	as stated
	To the Hospitel or Atlending Physician: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	edicai	(Check only 2 Medicel Execute)	eminer: On the basis of exa and manner stated	amination and/or in	vestigation, in my	opinion, death	occurred at the time, o	date and place, and c	lue to the cause(s)
	To the Hospitel within 24 hours a vithin 24 hours a To the Funeral to completely filled	Me	29b. Signature and title of certifier			29c. Licer	nse number	- 2	29d. Date signed (Mo	onth, Day, Year)
	6		9.11	Treda.			25947	7	BRUALLY.	22, 2006
	2		30. Name and address of person was	o completed cause of death					takengy.	,
			7 4 5 5 7 7 7 7	on mo 34h		to of the	T, SUIT	7 200, 0	year, mo	22812
	Sta Registr		31. Date filed (Month, Day, Year) FEB 2 8 2	32 Registrar's	aignature	WE				
	31011		~ 0 :	A. E. C. C. S. C. S. C.	no born	1947				

			1 - For State Registrar	State of Marylan	d / Depa	artment o			ntal Hygi	_	ые. б (	7826
			1. Decedent's Name (First, Middle, Last	)				2	. Date of Death			3. Time of Death
	Physici		JOHN EAST	IN WITHROW, JE	₹.				Month Feb. 22	Day 2006	Year	7:00 P <sup>M</sup>
}	/Medi Examir		4a. Facility Name (If not institution, give	street and number)		4b. City, Tow	n, or Location o		100. 22	4c. County		7.00 F
1			NATIONAL NAVAL MED	ICAL CENTER		Beth	esda			Mon	tgom	erv
	Funerai		5. Social Security Number 6. Se	x 7. Age (In yrs. I	ast birthday)	If Under 1 Y		24 Hrs. 8 Min.	Date of Birth (Month, Day,			lace (State or Foreign
	Director		404-38-6078	XM 2□F 75	Yrs.	WIOTIERS DE	lys Hours		ec. 1,			tucky
	pug *		Usual Residence of Decedent  10a. State 10b. County	10c Cib	, Town or Lo	cation						04 1-14-65-11-1
	er death with the Marylar Itams 23a or 28a-f show IEL must be notified at	ō		100. 010	7, 104110120	Cation					•	0d. Inside City Limits 1 ☐ Yes 2 ☑ No
	the N	ect	Virginia Fairfax 10e. Street and Number	Vie	enna	100 7: 0						
	with	급		_		10f. Zip Cod			10	g. Citizen of V	What Cour	itry?
	eath	era	10027 Lochness Cou	T I. 12. Was Decedent Ever in U.	S 13 V	Vas Decedent		nin? /Specif	hy Voe or No-	USA 14 Bac	e - Americ	an Indian
	fter dea r Itams inerm	Funeral Director	1 Never Married 2 Married	Armed Forces?		f Yes, specify (	of Hispanic Orig Cub <i>a</i> n, Mexican,	, Puerto Rio	can, etc.)		k, White,	
8	urs a	by	3 ☐ Widowed 4 ☐ Divorced	1 X Yes 2 No If Yes, Give 1953 Year or Dates: 1978	3-	1□Yes 2⊡x	No Specify:			Specify	· Wh	nite
Ò	72 hours after death with the Maryland natural', or Itams 23a or 28a-f show disal Eval in sermust be rectified at	Completed	15. Decedent's Edu	cation	16a. Deced	ient's Usual Do		- # who!	1	6b. Kind of B	usiness/Ind	dustry
2	within iene.	ple	(Specify only highest grad Elementary/Secondary (0-12)	College (1-4or 5+)	life. L	DO NOT use re	one during most tired)	or working				
2	Hygier Hygier Ither th	Co		5+	Offic	er-Cap	tain		U	.S. Na	vy	
Maryland 21215-0036	d d d	Be	17. Father's Name (First, Middle, Last)						First, Middle, M	aiden Suman	10)	
₹	should be ind Mental markad umatic av	2	John Eastin Withr					ha Pl				
Nar		n j	19a. Informant's Name/Relationship (T) Ann Hammarlund Mor				reet and Number			-	-	Code)
	s 1 and 2 should f Health and Mer item 27 Is marks othar traumatic						ess Cou					
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tra once.		20a. Method of Disposition 1 ♣ Burial 2 ☐ Cremation 3 ☐ F	Jamoual from State	ametery, cren	sition (Name o	place)	April	11,	0c. Location -	City or To	wn, State
ţ	It han the result of the resul		`4 □ Donation 5 □ Other (Specify)			Nation ery		200		rlingt	on, V	irginia
Bal	Deparimonal permit perm		21. Signatur, 1 uneral Service Licens	99	22	Name and Ad Money	dress of Facility & King	Funer	al Home	. Inc.		
	40200		muy reach	M		171 W.	Maple A	Ave	Vienna	. Va.	22180	
K			23a. Part1. Enter the disease, or compl shock, or heart failure. List only o	ne cause on each line.	. Do not ente	er the mode of	dying, such as o	cardiac or re	espiratory arres	st,		Approximate Interval Between Onset and Death
	Physician:	1	Immediate Cause (Final disease or condition resulting in death)	METASTATIC MA	LIGNAN	T MELAI	NOMA					Shoot and Boath
	/Medical Examiner			Due to (or as a consequ	ience of):							
		-	Sequentially list conditions,	Due to for as a conseque	ones off-						_	
	ted nsit	Examiner	cause. Enter Underlying Cause (Disease or injury	out to test as a consequence	CHARLE LITY							
•	al-tra	xar	that initiated events resulting in death) Last	Due to (or as a consequ	ence of):							
8760,	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	icalE										
89	ificate g phy as the	edic			1200							
Вох	leath certific attending p	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of pregnar						23d. Dat	e of delive	rv
	death e atte d for	Icla	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 Live birth 2 Fetal 4 Pregnant at time of de		Ectopic pregna Other (specify				Mor		Day Year
O.	t the or	hys	9 Unknown	9□ Unknown								
ر. ت	res that the de signed by the a be detached f	by P	Part II. Other significant conditions con	ntributing to death but not resu	lting in the un	derlying cause	given in Part I.		23e. Did toba	cco use contr	bute to th	e cause of death?
Records,	w require been sig should b								1 🗌 Yes	2 🖾 No	3 🔲 Proba	ably 4 🗆 Unknown
00	s bee	olet							24a. Was an	24b. V	Vere autop	sy findings available
æ	The lay te has age 2:	Completed			-				autopsy	ed? o	eath?	npletion of cause of
Vital	ysician: The is certificate hi director, page	0	25. Was case referred to medical				26. Place	of Death (C	1 ☐ Yes 2]		☐ Yes	2 L No
	Attending Physician: r death. actor: After this certific by the funeral director, i	To B	examiner? 1 ☐ Yes 2🌠 No	lospital: 1 XInpatient 2 2	ER/Outpatient	3 □ DOA	0.4		5 ☐ Residen		er (Specify	)
o L	ding Ph. h. After thi funeral		27. Manner of Death		28b. Time of Injury	28c. li	njury at Work?		I. Describe how			,
Ö	ttendir death. tor: Af the fur	atlo	14∑Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Bay Foar)	,ury		Yes 2 N	lo				
Division		Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At hor building, etc. (Specify,	me, farm, stre	et, factory, offi	се	28f.	Location (Stre		or Rural	Route Number,
	To tha Hospital or within 24 hours afte To tha Funaral Director Completely filled in the									·		
	To tha Hospital o within 24 hours aft To tha Funaral Di completely filled in	Medical	29a. Certifier 1 ☐ Certifying Phys (Check only 2 ☐ Medical Exami	sician: To the best of my knowner: On the basis of examinati	vledge, death	occurred at the	e time, date and	place, and	I due to the cau	se(s) and mai	nner as sta	ated.
	tha h in 24 tha h iplete	ledi	0116)	and manner stated.				- Occarred				
	on con	~	29b. Signature and title of certifier				ense number			I. Date signed		
	ı		· XX K	- MON			239146			02 /2		
			30. Name and address of person who consume SUNEIL R. RAMCHA			Print)			AVAL ME		CENTI	ER
			31. Date filed (Month, Day, Year)	NDANI LT MC	USN		RETHE	SDA M	D 20889	-5600		
	Sta Registr			06	ure do	mes						

			. For	State of Ma	ryland / Dep	artment of	Health and	Mental Hygi	iene	
			State Registrar		Ce	rtificate of	f Death		g. No. UU6	07827
*	Physici	<sub>э</sub> an	Decedent's Name (First, Middle,					2. Date of Death Month	n Day Year	3. Time of Death
	/Medic		Ronald Eugene  4a. Facility Name (If not institution.	Winebrenner	•	4b. City, Town,	or Location of De	February	7 27 2006 4c. County of Dea	16:28 P
	LXUIIII		19102 Woodhav	en Drive		На	gerstown		Washing	ton County
	Funeral			7. Age 1 <b>X</b> M 2 ☐ F	(In yrs. last birthday		r If Under 24 H	rs. 8. Date of Birth (Month, Day,	Year) 9. Bii	thplace (State or Foreign ountry)
	Director		208–28–7195 Usual Residence of Decedent		69 Yrs.			June 15	1936   Pe	nnsylvania
	ehow	_	10a. State 10b. County		10c. City, Town or L				·	10d. Inside City Limits
	28a-f	ecto	Maryland Wash	ington	Hage	rstown 10f. Zip Code		11	og. Citizen of What C	1 Tyes X No
	should be filed within 72 hours after death with the Maryland Ind Mental Hygiene. marked other then "neturet", or itema 23a or 28a-f ehow matic event, the Modical Exeminer must be notified at	Funeral Director	19102 Woodhav	en Drive			1742		U.S.	
	oma 2	Inera	11. Marital Status	12. Was Decedent E	ver in U.S. 13.	Was Decedent of	Hispanic Origin?	(Specify Yes or No- erto Rican, etc.)	14. Race - Am Black, Whi	erican Indian,
36	rs afte	by Fu	1 ☐ Never Married 2 X Marrie 3 ☐ Widowed 4 ☐ Divorced			1□Yes 2☒N		,	Specify: W	Tier.
8	2 hou	ted k	15. Decedent's	Education		edent's Usual Occ		1	16b. Kind of Business	/Industry
21215-0036	ithin 7	Completed	(Specify only highest Elementary/Secondary (0-12)	grade completed)  College (1-4or 5+	) /ife.	DO NOT use retir	,	rorking		
	filed w Hygier Sther th	Col	12 17. Father's Name (First, Middle, La	ist)		Presiden		ame (First, Middle, N	Trucking	Company
au	Mental arked o	To Be	Bill Wine					Kauffman		
Maryland	and M	-	19a. Informant's Name/Relationship		19b. Mai	ing Address (Stree	et and Number or	Rural Route Number,	City or Town, State,	Zip Code)
	l and lealth m 27 her tre		Inez D. Wineb	renner (wife			aven Dri	ve Hayerst		
nor	permit. Pages 1 and 2 should be Department of Health and Menta important: If Item 27 is marked eny injury or other traumatic esones.		20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3		20b. Place of Disp cemetery, cre Cedar La	amatory or other p			20c. Location - City or	
Baltimore,	nit. P partme cortani injury		4 ☐ Donation 5 ☐ Other (Special Service Lies)	•	1	2. Name and Add		Douglas A.		Maryland
ä	Dep imp	1	Duckart	Ling						rland 21742
3,			23a. Part1. Enter the disease, or conshock, or heart failure. List or	omplications that caused to the one cause on each line	he death. On not er	iter the mode of dy	ing, such as card	iac or respiratory arre	st,	Approximate Interval Between
1	Physician / /Medical		Immediate Cause (Final disease or condition resulting in death)	_ a	Ku	ng	COL	Men	(	3 months
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	n =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a	сопѕедиелсе об).					
	The law requires that the death certificate be executed the has been signed by the attending physician and page 2 should be detached for use as the burial-Iransit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a	consequence of):					
760,	te be ex nysician ne burial	icai E		Due to (or as a	consequence or).					
68	tificate ig phys as the			d						
Вох	eath certific attending p	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of 1 ☐ Live birth 2		□Ectopic pregnan	cy		23d. Date of de	
o.	at the dea by the at tached fo	ysici	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at ti 9☐ Unknown	me of death 5	Other (specify)	·		Month	Day Year
٥.	res that the igned by be detact	y Ph	Part II. Other significant condition	s contributing to death but	not resulting in the	underlying cause g	pven in Part I.	23e. Did tob	acco use contribute t	the cause of death?
Records,	w requires been sign should be	ed by	- Bre	xin v	neta	stag	<u> </u>	Ye	s 2□No 3□P	robably 4 🗆 Unknown
eco	e law re has bee je 2 sho	Completed						24a. Was an		utopsy findings available completion of cause of
_		Соп						perform 1 ☐ Yes 2	ed? death?	2 □ No
Vita	sician: Th certificate irector, pag	Be C	25. Was case referred to medical examiner?  1 Yes 2 No	Hospital:	• • • • • • • • • • • • • • • • • • •			eath Check only one		
Division of	E E =	n: To	27. Manner of Teath	1 ☐ Inpatient 28a. Date of Injury (Month, Day		III 30 DOX	4 🗀 14ui Siriy	Home 5 Resider		icity)
Sior	ending P eath. or: After t the funera	atio	Natural 5 Pending investiga	tion	Year) Injury		ork? ∃Yes 2⊟No			
Ž	o at io	Certification:	3 Suicide 6 Could no 4 Homicide determin	28e. Place of Injur building, etc.	y - At home, farm, s (Specify)	reet, factory, office	3	28f. Location (Str City or Town,	eet and Number or R State)	ural Route Number,
_	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the		29a. Certifying	Physician: To the best of	my knowledge, dea	th occurred at the	time, date and pla	ce, and due to the ca	use(s) and manner a	s stated.
,	the Ho	Medicai	one)	and manner state	xamination and/or it	ivestigation, in my	opinion, death oc	curred at the time, da	te and place, and du	e to the cause(s)
	With To	Σ	29b. Signature and title of certifier	1 1	MD	29c. Licer	nse number	29	d. Date signed (Mon	h, Day, Year)
7			BO, Name and address of person wi	no completed cause of do	ath (Item 23a) /Tuna	Crint	DHE	415	00/0	1106
_			Hind Han	ndan,	nD . 113	30 00	ALC	I. Hade	nstown	, MD 21740
1	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar	's Signature	1 .1.		1100		
3	negistr	-11		- WOOD A BORY	a 17. 1	200 50 B				

			1 - For Stata Registrar	State of			artmer	nt of H		nd Menta	ıl Hygie	•	6	078	28
	Physici /Medio	al	Decedent's Name (First, Middle     Emmett L. W:  4a. Facility Name (If not institution,	lson Jr.	har)		4h City	Town or	Location of	Febr		Day <b>20,</b> <i>Z Sc</i> 4c. County	7	3. Time of 0	Death M
	Examir Funeral Director	er	1.11	NM Med	dical	last birthday) Yrs.	-	<i>ک</i> r 1 Year	If Under 2	Hrs. 8. Date Min. (Mo	e of Birth inth, Day, Y	(ear)	9. Birth		
	Ba-f ehow	ctor	Usual Residence of Decedent  10a. State 10b. County  DE Susses		10c. C	ity, Town or Lo George								10d. Inside City 1 ☐ Yes 2	Limits
036	permit. Peges 1 end z should be lied within 7z hours after death with rine maryland Department of Health and Mental Hygiene. Department if them 27 is marked other than "natural", or iteme 23e or 28e-f ehow any injury or other treumatic event, the Madical Examiner must be motified at QDCs.	by Funeral Director	10e. Street and Number  15 BayBerry Sti  11. Marital Status  1 Never Married 2 Marria 3 Widowed 4 Divorced	12. Was Deced	es? X□ No		Vas Dece Yes, spe	199 dent of Hi cify Cuba		in? (Specify Ye Puerto Rican, ε			a - Ameri k, White	can Indian,	
d 21215-0036	Higher within 72 ho Hygiene. ther than "nature int, the Medical E	Completed	15. Decedent (Specify only highes Elementary/Secondary (0-12) 17. Father's Name (First, Middle, I	College (1-4	4or 5+)	16a. Decec (Give life. I		rk done d se retired	luring most (	of working	D C	ommuni	e Te ty C	chnical	. &
Maryland	should be and Mental s marked o umatic eve	To Be	Emmett L. Wils  19a. Informant's Name/Relationsh	son, Sr.		19b. Mailir	ig Address	(Street a	Bet	ılah Anı or Rural Route	n Nut	ter	-,	p Code)	
Baltimore, M	ant of Heelth and It if Item 27 if	3	Barbara Wilson  20a. Method of Disposition  1 Burial 2 Toremation  4 Donation 5 Other (Sp.	(wife) 3 □Removal from S	ate	Place of Dispo cemetery, crem	sition (Nai	me of other plac	9)	George Date	20	c. Location -	City or T		
Baltir	permit. r Departme Importan any injur		21. Signature of Funeral Service L	Hanniga M	01110	22 Ha	. Name ar	an-S	s of Facility hort–I	Disharo	t St.	Laure neral	1, D	e. 1995	6
E	The pricies and pricies are presented by the pricies and pricies and pricies are provided by the pricies are provided by the pricies are provided by the pricies are provided by the pricies are provided by the pricies are provided by the pricies are provided by the pricies are provided by the pricies are provided by the pricies are provided by the pricies are provided by the pricies are pricing and pricing are provided by the pricing are pricing are provided by the pricing are provided by the pricing are provided by the pricing are provided by the pricing are provided by the pricing are provided by the pricing are provided by the pricing are provided by the pricing are provided by the pricing are provided by the pricing are provided by the pricing are pricing are provided by the pricing are provided by the pricing are pricing a	Ilcai Examiner	23a. Part 1. Enter the disease, or shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (o  b. ALT(C  Due to (o	r as a conse JAU r as a conse	quence of):  E Q = 0.  quence of):	DRE	AN (	(seins	AZY ACT	thy 6	e Zymss		Approximate Interval Between Onset and De OAY'S	en iath
P.O. Box 68	Firstcien: The law requires that the death certificate be executed this certificate has been signed by the attending physicien and rat director, page 2 should be deteched for use as the buriat-transit	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		th 2 Fet nt at time of	aldeath 3□	Ectopic p					23d. Date Mor		ery Day Ye	ar
Records, P	w requires inat s been signed b should be dete	ted by Pł	Part II. Other significant conditio	ns contributing to dea	th but not re	sulting in the ur	nderlying o	ause give	on in Part I.	230	e. Did toba	100		the cause of dea	
tal Rec	nysicient. The law fins certificete has be	e Completed	25. Was case referred to medical								a. Was an autopsy performe Yes 2	rd2 0	rior to co	opsy findings averaged by the second	railable ise of
<b>C</b> :	g g g	Certification; To B	examiner?  1 Yes 2 No  27. Manner of Death  1 Natural 5 Pending 2 Accident investig 3 Suicide 6 Could n	28a. Date of (Month)	Injury Day Year)	28b. Time of Injury	M	28c. Injury Work 1 🔲	r: 4 ☐ Nurs	0	Resident	injury occurre	ed		
Δ	within 24 hours effect death.  To the Funeral Director: A completely filled in by the fu		4 Homicide determi	building	g, etc. (Spec	owledge, death	occurred	at the tim	e, date and	City	y or Town,	State)	nner 26 d	al Route Numbe	3 <i>r</i> ,
)	within 24 To the Fu	Medical	29b. Signature and title of certifies	and manne	r stated.	ation and/or inv	290	in my op License	number	occurred at the	e time, date	and place, and place,	ind due t	Day, Year)	
	Sta Registr		30. Name and addyss of person values of person values of the second of t	Todd 11	1	m 23a) (Type, 100 & ( ature	Carr		+5'	alishu	y 111	D			

DHMH 17 Rev 1/2001

Emmet Wilson 235-60-2607

			For State C	f Maryland / Departn <i>Certifi</i> e	nent of Health and No cate of Death	Mental Hygier	ZHIII	07829
	Physici	an	Decedent's Name (First, Middle, Last)		7	2. Date of Death Month	Day Year 15 200 C	3. Time of Death
	/Medic	al	A Coneth Maurica 4a. Facility Name (If not institution, give street and nu		City, Town, or Location of Death	·	5 ZOG 4c. County of Death	9 AM M
	Examin	er	PENINSULA REGIONAL MEDI		SALLSBURY		Hicini	20
	Funeral Director		5. Social Security Number 6. Sex 112 M 2□ F		Under 1 Year If Under 24 Hrs.  Onths Days Hours Min.	8. Date of Birth (Month, Day, Yea	9. Birthpl Coun	lace (State or Foreign try) M.D.
	and		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or Location	1	/ /	10	0d. In side City Limits
	Maryl a-f sho	tor	MD Wiconico	Salisha	ry			1 Yes 2 □ No
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Heelth and Mental Hygiene. Important: if Item 27 is marked other than "natural; or Items 23s or 28s-1 show any injury or other traumatic event, it a Medical Examinar must be notified at angle.	Funeral Director	10e. Street and Number		1. Zip Code	10g. (	Citizen of What Coun	try?
	ms 23e	era	11. Marital Status 12. Was Dec	edent Ever in U.S. 13. Was I	Decedent of Hispanic Origin? (Sp., specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - America	
9	or ite	y Fur	Armed For 1 Yes If Yes, Gi	2 7 No	, specify Cuban, Mexican, Puerto les 2∰No <i>Specify:</i> Д	Hican, etc.)	Specify: +	etc.
Ö	hours tural',	ed by	3 ☐ Widowed 4 ☐ Divorced Year or D	Dates:	Usual Occupation	ACAC 16b.	Kind of Business/Ind	lustry
215	thin 72 e. en "na	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (	(Give kind	of work done during most of work OT use retired)	ring )	//	,
121	iled wi Hygien ther th	Con	17. Father's Name (First, Middle, Last)	Coc		e (First, Middle, Maide	Oq. Wa	<u></u>
lanc	2 should be filed within 72 hours after and Mental Hygiene. ie marked other than "natural", or ite aumatic event, I', a Medical Examine.	To Be		Ward SR	Virg	ink F	on tall	Te
Maryland 21215-0036	2 should and he is maintained		19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Ad	dress (Street and Number of Run	al Route Number, City	or Town, State, Zip	()
ė. Z	1 and Heelth em 27 ther tr		Walter Bernard Ward SL. 20a. Method of Disposition	20b. Place of Disposition	(Name of	Date 20c.	Location - City or To	ud 0 1801
E P	Pages ent of nt: if it ry or o		1 DBurial 2 Cremation 3 Removal from 4 Donation 5 Other (Specify)	State cemetery, cremator			grion M	
3altimore,	permit. Depertminimporte		21. Signature of Funeral Service Licensee		ne and Address of Facility	nnie Smit	h Funera	Home
	₫ Q E <b>3</b> Q		23a. Part 1. Enter the disease, or complications that		I TSu be 11a st		, md 2180	Approximate
2	Physician		shock, or heart failure. List only one cause on Immediate Cause (Final	each line.	6	•		Interval Between Onset and Death
Le	/Medical Examiner		disease or condition resulting in death)  a  Due to	(or as a consequence of):	wit of vocal	Aphe Trau	inci	DCM47
B	LAMITIMET	ē	Sequentially list conditions b	(or as a consequence of):				
3203	executed in and ial-transit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events					
0 -	icate be executed physicien and s the burial-transit		resulting in death) Last Due to	(or as a consequence of):				
4 , √ 68760	ficate I physi s the t	edlcal	d					
Ward D. Box 68	eath certifi ettending for use as	an/M	230. Was decedent pregnant	tcome of pregnancy	pic pregnancy		23d. Date of delive	,
3 0	0 0	Completed by Physician/Me		nant at time of death 5 Doth	er (specify)		Month	Day Year
) (S	es that thighed by	y Ph	Part II. Other significant conditions contributing to c	leath but not resulting in the under	ying cause given in Part I.	23e. Did tobacci	o use contribute to th	e cause of death?
Records, F	v requires been sign should be	ted b				1 🗆 Yes	2 LLV6 3 □ Proba	ably 4 □Unknown
加	e jawr hes be je 2 sh	mple				24a. Was an autopsy performed?	prior to con	osy findings available inpletion of cause of
Vital F	ificete or, pag	S	25. Was case referred to medical		36 Place of Dool	1 ☐ Yes 2 ☐ A		2□ No
	nysicie nis cert direct	ToB	examiner?	Inpatient 2 ER/Outpatient 3	Othor	ome 5 Residence	6 ☐Other (Specify	)
Division of	ling Ph 1. After th uneral			of Injury 28b. Time of Injury	28c. Injury at Work? 1 ☐ Yes 2 ☑•No	28d. Describe how in	jury occurred	
isic	Attender death	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place	a of Injury - At home, farm, street, fling, etc. (Specify)		28f Location (Street	and Number or Rura	Route Number,
á	itel or rs afte at Dire	Cert		ing, etc. (Specify)		City or Town, Sta	Shad landing	D. MO
	To the Hospital or Attending Physicien: The law within 24 hours alter death. To the Funerelt Director; After this certificate has completely filled in by the funeral director, page 2.	edical	(Check only 2 Medical Examiner: On the b	e best of my knowledge, death occ basis of examination and/or investion oner stated.	urred at the time, date and place, pation, in my opinion, death occur	and due to the cause red at the time, date a	(s) and manner as stand due to	ated. the cause(s)
	To the within : To the somple	Med	29b. Signature and title of certifier	states.	29c. License number	29d. I	Date signed (Month, L	Day, Year)
			· Cluby		1450497	2/	25/06	
			30. Name and address of person who completed cau CHRIS SNYGH 100 E	se of death (Item 23a) (Type, Print	306/Shun mo			
	Sta	ite	31. Date filed (Month, Day, Year) 32. I	CAIDII ST.	Challen 1110			
	Registr	rar	FEB 2 8 2006	House H. Son	Mr. 1			

_	Registrar	
	For State Registrar	State of Maryland / Department of Health and Certificate of Death

Mental Hygiene 06 07830

			7 - State Registrar		Ce	rtificate of E	Death	F	leg. No.	01000
			Decedent's Name (First, Middle, La.	st)				2. Date of Dea	D- 14	3. Time of Death
	rysici: Medic		Max Benno	o Weiser				Feb. 2	23, 2006	8:05 PM
	xamin		4a. Facility Name (If not institution, give			4b. City, Town, or			4c. County of De	
1.7877 1765 - 188		į.	Vindabona Nurs				caddock		Frede	
	neral ector		109-20-2307	91 7. Age ( <i>In yr</i> s. 91)	/ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth Month Day Apr •	1°1°, 1918	irthplace (State or Foreign County)   Germany
and	-		Usuef Residence of Decedent  10a. State 10b. County	10c. Ci	ty, Town or Lo	ocation				10d. Inside City Limits
Mary	lieut	ğ	MD Free	derick		Adamstov	vn			1 X Yes 2 ☐ No
the the	Treat	Director	10e. Street and Number			10f. Zip Code		1	10g. Citizen of What (	Country?
eath with	ount be			aker Circle		2171			USA	
72 hours after death with the Maryland frature! or items 23s or 28s.f show	Exerciper rotest by notified at	l by Funerai	11. Marital Status  1 □ Never Married 2 □ Married  3 ত Widowed 4 □ Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates:		Was Decedent of His If Yes, specify Cubar 1 ☐ Yes 2 No	Specify:	o Rican, etc.)	Black, Wh	
72 h	dical	Completed	15. Decedent's Ed (Specify only highest gra	ducation de completed)	(Give	dent's Usual Occupa kind of work done d	uring most of won	king	16b. Kind of Busines	s/Industry
within ene.	28	m id id	Elementary/Secondary (0-t2)	College (1-4or 5+)	life.	DO NOT use retired)				
filed with	H H		12 17. Father's Name (First, Middle, Last)			furrier	18. Mother's Nam	ne (First Middle	texti	e
	other traumatic event, the M	Be c	Benjamin Weise					Unknov	,	
2 should be and Mental	matic	ဥ	19a. Informant's Name/Relationship (		19h Mailir	no Address (Street a			r, City or Town, State,	Zin Code)
0 5 h	trau		Dr. Benjamin V			_			Letown, N	· ·
Hea E	othe		20a. Method of Disposition	20b. I	Place of Dispo	osition (Name of			20c. Location - City of	
permit. Pages 1 an Department of Heal	ry or		1 Burtal 2 □ Cremation 3 □ 4 □ Donation 5 □ Other Specif			matory or other place ark Ceme		/26/06	Westwood	l, New Jer
mit.	a P		21. Signature of Fundral Service Licer						neral Hon	
	eny i	1	, myour	april	3	1 E. mai	in St.,	Middle	etown, MI	21769
Physi /Med Exam	dical		234 Part 1. Errier the disease, or com short, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. Acule a Due to (or as a consec b. arleris 1	(uence of):	andial	chevare	or respiratory arr	Duck	Approximate Interval Between Onset and Death
certificate be executed	ise as the burial-transit	/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury that initiated events resulting in death) Last	C. Due to (or as a consect d						) 0
the death certiff	should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9  Unknown	23c. If yes, outcome of pregn. 1 Live birth 2 Feta 4 Pregnant at time of c	if death 3	Ectopic pregnancy Other (specify)			23d. Date of do Month	blivery Day Year
s that	e deta	by Pt	Part II. Other significant conditions of	ontributing to death but not res	ulting in the u	nderlying cause give	n in Part I.	23e. Did to	bacco use contribute	to the cause of death?
quire	d blu	a pa	diabeter	- ,- ,- ,- ,- ,- ,- ,- ,- ,- ,- ,- ,- ,-				1 🗆 Y	es 2□No 3□F	Probably 4 Nnknown
a v re	2 sho	Completed	hypertein	ė-				24a. Was a		utopsy findings available
The	oage	E O						autops perform	med? death?	completion of cause of
ian:	ctor,	Bec	25. Was case referred to medical examiner?				26. Place of Dea	th (Check only on	<b>A</b>	
nysic nysic	dire	2	1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatier	nt 3 DOA Othe	r: 4 Nursing H	ome 5 Reside	ence 6 Other (Sp	ecify)
2 E E	nera		27. Manner of Death 1. Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	f 28c. Injury Work	at ?	28d. Describe ho	ow injury occurred	
tendi leath.	the fu	cati	2 Accident investigation 3 Suicide 6 Could not be				es 2 □ No			
el or At s after o	d in by	Certification:	4 Homicide determined	28e. Place of Injury - At h building, etc. (Special	ome, farm, str fy)	reet, factory, office	4	28f. Location (Si City or Town	treet and Number or F n, State)	Rural Route Number,
To the Hospitel or Attending Physician: The law requires that the death within 24 buous after death.  Within 24 buous after death.	completely filled in by the funeral director, page 2	edicai	29a. Certifying Ph (Check only one)	ysician: To the best of my knoniner: On the basis of examina and manner stated.	owledge, death ation and/or in	h occurred at the time vestigation, in my op	e, date and place, inion, death occur	and due to the cared at the time, d	ause(s) and manner a ate and place, and du	s stated. e to the cause(s)
To t	com	Σ	29b. Signature and title of certifier	110-	A. A	29c. License	number	2	9d. Date signed (Mor	
			W.	Myon	FU	101	66/5		PEB. 24	+,2006
3			30. Name and address of person who	completed cause of death (Iter	n 23a) (7x0e,		MN	2171	(	

Registrar
DHMH 17 Rev 1/2001

State

		1	For Amend Item 23a per	of Maryland Dr., G853,	03212 03212	rtment of Heal (06dhb tificate of Dea	th and Me a <i>th</i>	ntal Hygi	ene g. No.	06	07831
			Decedent's Name (First, Middle, Last)				2	. Date of Deatl Month	Day	Year	3. Time of Death
	Physicia		ETHEL L.			WISE	М	ARCH	04	2006	7:15A M
	/Medic Examin		la. Facility Name (If not institution, give street and nu FOREST HILL HEALTH & R		ER	4b. City, Town, or Loca FOREST HI	tion of Death			unty of Death	
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last		If Under 1 Year   If U	nder 24 Hrs.   g	. Date of Birth		9. Birthpla	ace (State or Foreign
	Funeral Director		185-34-9330 1□M 2\sqrt	92	Yrs.	Months Days Ho	urs Min.	(Month, Pay, 1/28/19	13	Penns	yvy Sylvania
	D .		Usual Residence of Decedent	140 00 -						10	d. Inside City Limits
	Marylar -f show fied at	to	10a. State 10b. County PA York	10c. City, T Fav	wn Gr						1 ☐ Yes 2 🕅 No
	with the 3a or 28e	I Director	10e. Street and Number 474 Gross Road			10f. Zip Code 17321		10	og. Citizen US	of What Count	ry?
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or flems 23a or 28e-1 show any injury or other treumatic event, the Medical Examiliation and the analysis and the free matter and the analysis.	by Fur	Armed F	2 <b>™</b> No ive	l If	Vas Decedent of Hispani Yes, specify Cuban, Me	ic Origin? (Speci exican, Puerto Ri ecify:	fy Yes or No- can, etc.)		Race - America Black, White, e ecity: Whit	etc.
21215-0036	n "nature	Completed	15. Decedent's Education (Specify only highest grade completed		(Give life. L	lent's Usual Occupation kind of work done during OO NOT use retired)	most of working			of Business/Ind	ustry
212	d with giene grithe	E	Elementary/Secondary (0-12) College	(1-401-54)	Home	maker —————			Own	1 Home	
פר	e file al Hyg othe vent,	ВеС	17. Father's Name (First, Middle, Last)			18. 8	Mother's Name (		faiden Sui	mame)	
<u>Ja</u>	Menta Menta arked	10	Hugh Thomas Smith				Ida Ho				
Maryland	2 sho and is ma	1	19a. Informant's Name/Relationship (Type, Print) Betty Hoover/Daughter			g Address (Street and N					Code)
≥,	and lealth m 27 her tr	Ŋ.		20h Plac		Gross Road,	rawn Gi			321 ion - City or Tov	wn State
altimore,	Pages 1 nent of H ant: If ite ury or ot		20a. Method of Disposition    ↑23Burial 2 □ Cremation 3 □ Removal from  ↑4 □ Donation 5 □ Other (Specify)	cem	etery, cren	natory or other place) 1e Cemetery				a, PA	
Balt	permit. Departs Imports any inj once.		21. Signature of Funeral Service Licensee	relede	H:	Name and Address of I arkins Fune	ral Home			ta, PA	17314
8760,	itions be executed // Medical Examiner superior and superior and superior s	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Crisease of injury that initiated events c.	Hypertens o (or as a consequer o (or as a consequer	nce of):						Onset and Death
O. Box 68	it the death certificaby the attending place hed for use as t	Physiclan/Med	23b. Was decedent pregnant	utcome of pregnanc birth 2 Fetal de gnant at time of deat nown	ath 3	Ectopic pregnancy Other (specify)			23d	. Date of delive Month	ry Day Year
S, D	ires the signed d be de	by	Part II. Other significant conditions contributing to	death but not resulti	ng in the u	nderlying cause given in	Part I.				e cause of death?
Record	e law has t je 2 s	Completed						24a. Was a autops perform	У		osy findings available inpletion of cause of
Vital	i <b>cian</b> : Th certificate rector, pag	Be C	25. Was case referred to medical examiner?				Place of Death				
of V	S S	은	1 ☐ Yes 250 No Hospital: 1 ☐		VOutpatier		Mursing Hom				")
	ng fter	atlon:		e of Injury onth, Day Year)	8b. Time o Injury	f 28c. Injury at Work?  M 1 Tyes		3d. Describe ho	w injury o	ccurred	
Division	tel or Attendi s after death. af Director: A ed in by the fu	ertification:	3 Suicide 6 Could not be determined 28e. Pla buil	ce of Injury - At hom ding, etc. (Specify)	e, farm, str	reet, factory, office	28	Bf. Location (St City or Town	reet and N n, State)	lumber or Rura	l Route Number,
-	To the Hospitel or within 24 hours after To the Funeral Directory completely filled in E	edical C	29a. Certifier (Check only one) Certifying Physician: To t	he best of my knowle basis of examination	edge, deat n and/or in	h occurred at the time, divestigation, in my opinion	ate and place, ar n, death occurred	nd due to the ca	ause(s) an ate and pla	d manner as st ace, and due to	ated. the cause(s)
	To th Within To th	₩ Me	29b. Signature and title of certifier			29c. License nur	nber	2	9d. Date s	igned (Month,	Dey, Year)
			David 30			635	-235	6	nor	cu L,	2066
-	10		DR. DAVID DUNN, 615 W.	MACPHAIL	ROAD	, BEL AIR,	MD 210	14			
	St Regist	ate rar	At .	Registrar's Signatur	Josef						

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician HENRY** K. S. YEE 23 2006 2:45 PM February /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Brooke Grove-Meadows Nursing Home 01ney Montgomery If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 ☑ M 2 ☐ F Yrs 579.30.9242 90 Director April 22,1915 China Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "naturel; or items 23a or 28a-f show any injury or other traumatic event, the Modeal Expriner must be notified at anones. 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 17√T Yes 2 □ No Director Maryland Montgomery Silver Spring 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 13012 Hathaway Drive 20906 U.S.A. Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 X Yes 2 □ No If Yes, Give Year or Dates: WW II 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2K No Specify Specify: Asian ģ 3X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Restaurant Services 12th Entrepreneur 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ηi Oh Lau ဥ (Unknown) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Susan Yee King/Daughter 3808 Mt. Olney Lane, Olney, Maryland 20832 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ₺ Burial 2 □ Cremation 3 □ Removal from State 02/28/06 Silver Spring, MD Gate of Heaven Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
HINES-RINALDI FUNERAL HOME, INC. 21. Signature of Funeral Service Licensee 11800 New Hampshire Ave, Silver Spring, MD 20904 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or head failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Preumonis 12 hours Examiner Due to (or as a consequence of): Examiner Emply sems. the attending physician end thed for use as the bunal-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated over 15 resulting in death) Last o (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical Due to for as a consequence of should be detached for use as 23b. Did tobacco use contribute to the ceuse of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 1 No 3 Probably 4 Unknown signed by ò 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Completed peen After this certificate hes 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No I or Attending Physicien: after death. ours after death.

erel Director: After this certificatiled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4MNursing Home 5 - Residence 6 - Other (Specify) 1 Yes 2 No Certification: To 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 24 hours Hospital time Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) To the I within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number February 1) 33700 23,2006 12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21795 WILLIAMSPORT, MD 154 N. ARTIZAN ST. IED HOWE 31. Date filed (Month, Day, Year) FEB 2.8 32 Registrar's Signature

**DHMH 16 Rev 6/95** 

State

Registrar

2006

			For State Registrar	State of M	/larylan		artment rtificate			nd Mental H	ygiene Reg. No	UUb	078	33
	Dhyolei		1. Decedent's Name (First, Middle,	Last)					7.2	2. Date of I	Death Da	y Yee	3. Time o	f Death
¥ via	Physici /Medic		Beatrice Joy							The state of the s	lary o	200	6 4:25	P,M.
1	Examin	ner	4a. Facility Name (If not institution,					Town, or Lo				. County of De		a+
			Washington Co			last birthday)	If Under		rstowi If Under 24				ton Cou	
1	Funeral Director		219–36–2924	1 □ M 2/QXF	79		Months			Min. (Month, I	рау, Year) 19 19		Birthplace (State of Country) Pennsylv	
	D.		Usual Residence of Decedent							Dan	12.1.			
	a-f ehow	ctor	Maryland Wash	ington	10c. Cit	Hager		ì					10d. Inside C	ity Limits 2 No
	3a or 28	i Director	10e. Street and Number 54 West Side	Ave			10f. Zip		1740		10g. Cit	tizen of What U.S.		
980	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 ie marked other than "natural", or itema 23a or 28a-f ehow other traumatic event, the Madical Examinating that willing at	by Funeral	11. Marital Status  1 Never Married 2 Marrie 3 Widowed 4 Divorced	12. Was Deceder Armed Force d 1 Yes 2 If Yes, Give Year or Oates	s? <b>X</b> No		Was Deced f Yes, spec			n? (Specify Yes or f Puerto Rican, etc.)	No-	14. Race - Ai Black, W Specify:	merican Indian, hite, etc. Black	
21215-0036	ithin 72 hc ie. ien *natul	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0·12)	Education grade completed) College (1-4o	r 5+)	life.	kind of wor DO NOT us	k done dur e retired)	on ring most o	f working		ind of Busine		20
	filed withi Hygiene. other than		12	.,		НС	omemak						Residen	ce
Maryland	2 should be filed and Mental Hygis Ie marked other aumatic event,	To Be	17. Father's Name (First, Middle, La William McKinle		•			18		Name (First, Midd a William				
Mar	2 sho	6 11	19a. Informant's Name/Relationshi							or Rural Route Num				
	Health tem 27 other tra		Raymond M. Young	g (son)	20h F	70 Place of Dispo			t. Ha	gerstown	_		or Town, State	
Baltimore,	Pages nent of h int: If its iry or of		1 ☑ Burial 2 ☐ Cremation 3		ie C	cemetery, crei	natory or of	ther place)						-
Ħ	permit. Page Department o Important: If eny injury or pnce.		4 ☐ Donation 5 ☐ Other (Special Signature of Funeral Service Li		Ros	se Hil	L Ceme			-2 <b>-</b> 06			vn Maryla	
Ba	permit. F Departm Importar eny injur		Muyla	A Frin	/		1331 E	Easter	rn Bl	vd. N. Ha	gerst			21742
в			23a. Part1. Enter the disease, or c shock, or heart failure. List or	omplications that caus	ed the deat line.	h. Do not ent	er the mode	of dying,	such as ca	rdiac or respiratory	arrest,		Approxima Interval Bei Onset and	ween
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Five	Sire	01/	A					<u>.</u>		
	Examiner			Due to (or a	as a conseq	uence of):								
	3 3	er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or r	35 3 CONSEC	uence of):								· · · · · · · · · · · · · · · · · · ·
	outed ansit	Examiner	Cause (Disease or injury that initiated events	G										
o,	sate be executed bhysician and the burial-transit	Ä	resulting in death) Last	Due to (or a	as a conseq	juence of):								
68760,	ate be hysici the bu	dicai		d										
.O. Box 6	ne death certific the attending p thed for use as	Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	23c. If yes, outcom 1 ☐ Live birth 4 ☐ Pregnant 9 ☐ Unknown	2 Feta	Ideath 3	Ectopic pre			-		23d. Date of o Month		Year
0	res that th igned by be detac		Part II. Other significant condition	s contributing to death	but not res	ulting in the u	nderlying ca	ause given	in Part I.			, ·	o to the cause of o	
0	v requir	eted	20/VG C	7000						_	Yes 2		Probably 4	Unknown
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Vita	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:				2 Dther:		Death (Check only				
of	무두등	T.	1 ☐ Yes 2 No 27. Manner of Death	28a. Date of Ir	niurv	ER/Outpatier 28b. Time of		^	4 U IVUIS	ng Home 5 ☐ Re 28d. Describ			pecify)	
on	ding R th. : After funera	tlon	1 Natural 5 Pending 2 Accident investiga	(Month, L	Day Year)	Injury	м	8c. Injury at Work? 1 ☐ Ye	s 2 □ No		5 1.01v #1ju	,, 55541154		
Division	al or Attending I safter death. I Director: After d in by the funer	Certification:	3 Suicide 6 Could no 4 Homicide determin	ed 286. Place of	Injury - At he etc. (Specif	ome, farm, str fy)	eet, factory	, office			(Street ar own, State		Rural Route Nun	nber,
	To the Hospital or Attent within 24 hours after deatl To the Funeral Director: completely filled in by the	edical C	29a. Certifier 1 Certifying (Check only one)	Physician: To the be kaminer: On the basis and manner	of examina	owledge, deat ation and/or in	n occurred a vestigation,	at the time, in my opin	date and paid	place, and due to the occurred at the time	e cause(s e, date and	) and manner d place, and c	as stated. due to the cause(s	5)
	To the vithin To the comple	Med	29b. Signature and title of certifier	2			29c	. License n	number		29d. Da	te signed (Mo	onth, Day, Year)	
	- > = 0		1	200			10	200	55	74	2/	27	106	
	6		30. Name and address of person w	ho completed cause o	f death (Iter	п 23а) (Туре,	Print)	- ~A	1 a A	Dr. HI	75	1445	2/2/21	1/12
	Sta Registi		31. Date filed (Month, Day, Year)	137	strar's Signa	ature	lace the	- <del> </del>	7,00		7-3	7.0	5///	
1	\$ · · · · · · · · · · · · · · · · ·		TAMPA TAMPA	a mood y	PSLIN-	10. la	10							

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 006 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 115AM March 2006 Charles Norman Anderson, Sr. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Mahra Brond Brundel Baltimore Washington Durnich (2/12 6. Sex If Under 1 Year | If Under 24 Hrs. | 8 Date of Birth (Month, Day, Year) 7/29/1915 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1⊠M 2□F Yrs. 212-03-5761 90 Director Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits rthan "natural", or itama 23a or 28a-f ahov the Medical Examiner must be notified at 1 ☐ Yes 2 X No Director Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8125 Ventnor Road 21122 USA Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 21 No Specify: Specify Completed by 3 Widowed 4 □ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Il Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Lab Chemist Chemical Company permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygie Important: if Itam 27 is marked other th any injury or other traumatic avent, Ilba once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ၉ Charles N. Anderson Lena Hoffman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles N. Anderson Jr./Son 367 Eagle Hill Rd., Pasadena, MD 21122 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cedar Hill Cemetery 13/14/2006 Baltimore, MD 21. Signature of Foneral Service Ligensee 22. Name and Address of Facility Stallings Funeral Home, P.A. 3111 Mountain Rd., Pasadena, MD 21122 23a. Part1. Enter the cease, or c shock, or heart fail re. List or polications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. or co Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) o le Physician /Medical Due to (or as a consequence of): Examiner Sequentially tist conditions, if any, leading to immediate cause. Enter Under vind Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequiattending physician and for use as the burial-transit Due to (or as a consequence of): Box 68760 by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetat death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 Other (specify) o 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Medical Certification; To Be Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 7 No performed? 1☐ Yes 2☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No Inpatient 2 ER/Outpatient 3 DOA this 28c. Injury at Work? 27. Manper of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred \* Hatural 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 🗋 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by 4 Homicide within 24 hours a

To the Funeral C

completely filled 29a Certifier 🕰 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and little of certifier 29d. Date signed (Month, Day, Year)

State

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

O VA

5 2006

31. Date filed (Month, Day, Year)

MAR 1

			For	State of Maryland				•	9	07935
			For State Registrar	,	•	tificate of L		, ,	g. No.	07000
	Dharaini		1. Decedent's Name (First, Middle, Last)				-	2. Date of Death Month	Day Year	3. Time of Death
	Physici /Medic		Cecil D. Amos, Sr.						2, 2006	9:00P M
	Examin	er	4a. Facility Name (If not institution, give s			4b. City, Town, or		ath	4c. County of Dea	
	F		Mariner Health of  5. Social Security Number 6. Sex		ast birthday)	Glen Bur	nne If Under 24 Hi		Anne A	
	Funeral Director			(M 2□F 71	Yrs.	Months Days	Hours Mi	n. (Month, Day, 3/29/19	Year) C	nthplace (State or Foreign ountry)
5			Usuat Residence of Decedent  10a. State 10b. County	100 Cib	, Town or Lo	ontion	· · · · · · · · · · · · · · · · · · ·			10d. Inside City Limits
Aprilo	o ho	٥				Cation				1 ☐ Yes 2 ☑ No
d of	289	Director	MD Anne Arur  10e. Street and Number	ide i Bro	oklyn	10f. Zip Code		10	g. Citizen of What C	ountry?
Laction Mandage	38 o	O I	109 E. Cedar Hill	Lane		21225			USA	
100	E B	Funeral	11. Marital Status	2. Was Decedent Ever in U. Armed Forces?	S. 13. \	Was Decedent of Hi f Yes, specify Cubar	spanic Origin?	(Specify Yes or No- erto Rican, etc.)	14. Race - Am Black, Whi	
-0036	o' l	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☑ Divorced	1 ☐ Yes 2 🕅 No If Yes, Give	1	I□Yes 2⊠ No	Specify:			White
		edb	15. Decedent's Educ	Year or Dates:	16a. Deced	lent's Usual Occupa	ition	1	6b. Kind of Business	
G L Z L	Madi	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	(Give life. l	kind of work done of OO NOT use retired,	luring most of w )	orking		ŕ
	Hygiene ther the	Con	8		Custo	dian			Retail	
		Be	17. Father's Name (First, Middle, Last)					ame (First, Middle, M	laiden Sumame)	
Maryland	d Mer mark matic	ဥ	Cecil D. Amos  19a. Informant's Name/Relationship (Ty)	ne Print)	19h Mailir	ng Address (Street a	Alice	Rural Route Number,	City or Town State	Zin Codel
Z S	f Health and Mer item 27 is marke other traumatic		Tina Randall/daugh			•		Baltimore		
ē,	item item othe		20a. Method of Disposition	20b. P	ace of Dispo	sition (Name of natory or other place			Oc. Location - City or	
	artment of ortant: If it injury or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emovar from State	-	matory		В	altimore.	MD
Baltimore,	Departiment any in land		21. Signatur of Ameral Service Linen e		22	. Name and Addres	_	Stallings	Funeral Ho	ome, P.A.
,	707 9 9		220 Post 1 Extends of complete	as ions had an ead the death	. Do not ont	3111 Mour	ntain Ro	l., Pasade	na, MD 211	22 Approximate
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	hysician /Medical		disease or condition resulting in death)	Due to (or as a consequ	c Of	structi	re bus	nonery I	rose	years
Ε	xaminer			200 10 (01 00 0 0010040	30.100 0.7.			96		
/ 3	=	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury	Due to (or as a consequ	ence of):					
\ \frac{1}{2}	and I-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequ	ience of):					
/6U, /	nysicien and he burial-translt	calE		200 10 (01 00 2 00 110040	201100 017.					
	g phys			•						
. Box 68	attending phy	M/W	23b. Was decedent pregnant	3c. If yes, outcome of pregna 1□Live birth 2□Fetal		Ectopic pregnancy			23d. Date of de	
J. E.	, 6 2	by Physician/Med	in the past 12 months? 1  Yes 2 No 9 Unknown	4 Pregnant at time of de 9 Unknown		Other (specify)			Month	Day Year
J. 1	d by letach	Phy	Part II. Other significant conditions cor	tributing to death but not resu	ulting in the u	nderlying cause give	on in Part I	23a. Did tob	acco use contribute t	to the cause of death?
Vital Records, P.O	been signed by the should be detached	d by	114 . 151	i Wation		idony ing daddo give	AT 11 T CAN 1.			robably 4 Unknown
o S	peed	Completed	U					24a. Was an	24b. Were a	utopsy findings available
2 g	te has age 2	mo						autopsy perform	ed? prior to death?	completion of cause of s 2 No
		BeC	25. Was case referred to medical examiner?					eath (Check only one		2 2 140
> 1	this certificate has	2	1 ☐ Yes 2 Ŋ No		ER/Outpatien		Tigg (Valoring	Home 5 Reside		ecify)
Division of Vita	7 Ja G	ion:	27. Manner of Death  1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Work	at ? /es 2 ⊡No	28d. Describe ho	w injury occurred	
/ISI	efter death Director: /	ficat	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - At ho	me, farm, str			28f. Location (Str	eet and Number or F	Rural Route Number,
á	within 24 hours effect death.  To the Funerei Director: A completely filled in by the to	Certification;	4  Homicide determined	building, etc. (Specify	")	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		City or Town,	State)	
1000	uner uner uner	edical (	29a. Certifier 15 Certifying Phys	sician: To the best of my knowner: On the basis of examinat	wledge, death	occurred at the time	e, date and pla	ce, and due to the ca	use(s) and manner a	s stated.
4	hin 24 the F	Medi	one) 29b. Signature and title of certifier	and manner stated.		29c. License			d. Date signed (Mon	
F	5 ₹ <b>5</b> 8	-	MOLLOWY	MO				\(\rangle \)		
	1		30. Name and address of person who co	mpleted cause of death (Item	23a) (Tyne	Print) 775 U	odnite.	Anima		
	7		30. Name and address of person who con DR. Stranger 31. Date filed (Month, Day, Year)  MAR 1 5 2006	p	( )	suite 72	8 0	Ten Burn	rie, MD 2	1061
	Sta	ite	31. Date filed (Month, Day, Year)	32. Registrar's Signa	ture And	de)			1	
	Registr	ar	MAR 1 5 2008	Herra St	J. Spilos					

		State Registrar	ite of Maryland		tificate of I		Re	g. No.	07836
Physici	an	1. Decedent's Name (First, Middle, Last)  Cheryl S. Alexander					2. Date of Death Month March 1	Day Year	3. Time of Death 3:55 AM M
/Medic Examin		4a. Facility Name (If not institution, give street	and number)		4b. City, Town, or	Location of Death		4c. County of Deat	th .
		12321 Falls Road			Mile de ed Vese	Cockeysv:		Baltimor	
Funeral Director		5. Social Security Number 245-72-5470 6. Sex	7. Age (In yrs. Ia 60	Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth Month, Day, 05/21/	9. Bin 1945 CA	hplace (State or Foreign untry)
yland now		Usual Residence of Decedent  10a. State 10b. County	10c. City,	Town or Loc	cation				10d. Inside City Limits
e Man sa-f eh	Director	MD Baltimore	Cod	ckeysv	ille				1 Tyes 2 No
n with th		10e. Street and Number 12321 Falls Road			10f. Zip Code 21030			g. Citizen of What Co United Sta	·
should be filed within 72 hours after death with the Maryland nod Mental Hygiene. In a Maryland should be shown to the the formatic event, the Medical Examinar must be notified.	by Funeral	Ar	as Decedent Ever in U.S med Forces? Yes 2 No /es, Give ar or Dates:		Vas Decedent of H Yes, specify Cuba	ispanic Origin? (Spent) In, Mexican, Puerto Specify:	ecfy Yes or No- Rican, etc.)	14. Race - Ame Black, Whit Specify: Wh	e, etc.
72 ho	eted	15. Decedent's Education (Specify only highest grade com	pleted)	(Give I	ent's Usual Occupa	durina most of worki	ing 1	6b. Kind of Business	
within ane. then	Completed		llege (1-4or 5+) 5+	life. D	OONOT use retired <b>essor</b>	)		Health	rubite
d be filed antal Hygic	Be	17. Father's Name (First, Middle, Last)  James Sedlacek				18. Mother's Name Frances	(First, Middle, M Adcock	aiden Sumame)	
~ ~ ~ ~ ~	To	19a. Informant's Name/Relationship (Туре, Pr Richard Cain/Husband	int)					City or Town, State, 2	
permit. Pages 1 and 2 Department of Health Important: If Item 27 I any Injury or other tra once.		20a. Method of Disposition 1 ☐ Burial 2:★Cremation 3 ☐ Remov. 4 ☐ Donation 5 ☐ Other (Specify)	al from State	metery, crem	sition (Name of natory or other place ake Crema	tory	Mar 14	Oc. Location - City or Beltsville	
permit. Pag Department Important: I any Injury o	Ì	21. Signature of Funeral Service Licensee	a Walle	-		and Funera		atives altimore, M	aruland
		23a. Part1. Enter the disease, or complication	s that caused the death.	7-21					Approximate Interval Between
Physician /Medical Examiner		shock, or heart failure. List only one cau Immediate Cause (Final disease or condition resulting in death)	Metastata Due to (or as a consequence		um M.	elanomo	ŝ		Onset and Death
	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	Due to (or as a consequ	ance oi).					
ticate be executed physicien and is the burial-transit	edicai Exa		Due to (or as a conseque	ence of):					
rtificat	Medi	IF FEMALE:							
To the Hospitel or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funerel Director: After this certificate has been signed by the ettending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/M	23b. Was decedent pregnant in the past 12 months?	res, outcome of pregnan □Live birth 2 □ Fetal o □ Pregnant at time of dea □ Unknown	death 3 🗆	Ectopic pregnancy Other (specify)			23d. Date of del Month	ivery Day Year
wrequires that the de been signed by the should be detached	by	Part II. Other significant conditions contribute	ng to death but not resul	lting in the ur	iderlying cause give	en in Part I.	23e. Did toba	acco use contribute to	o the cause of death?
Physician: The law re Physician: The law re rthis certilicete has bee ral director, page 2 sho	Completed						24a. Was an autopsy perform	ed? prior to death?	utopsy findings available completion of cause of
ician: Sertitica Sector,	Be	25. Was case referred to medical examiner?	1.		Oth	26. Place of Death			
Physic ruthis or rail dir	7:	1 ☐ Yes 2 PNo Hospita 27. Manner of Death 28s	1   Inpatient 2   E	R/Outpatient 28b. Time of	t 3□ DOA Oth	4 🗆 Nuising Ho	me 5 Resider 28d. Describe hov	nce 6 Other (Spe	cify)
ndIng sth. r: Afte	atlon	1 Natural 5 Pending 2 Accident Investigation	(Month, Day Year)	Injury	Worl	k?` Yes 2 □No		,,	
To the Hospitel or Attending Physician: The within 24 hours alter death. To the Funeret Director: Atter this certificete his completely filled in by the funeral director, page	Certification;	3 Suicide 6 Could not be determined 286	Place of Injury - At hor building, etc. (Specify)	me, farm, stre	eet, factory, office		28f. Location (Stre City or Town,	eet and Number or Ri State)	ural Route Number,
ne Hospit 124 hours ne Funere iletely fille	edical	29a. Certifier (Check only one) 1 Certifying Physician 2 Medical Examiner: C	To the best of my known the basis of examinating manner stated.	rledge, death on and/or inv	occurred at the tingestigation, in my o	ne, date and place, pinion, death occurr	and due to the car ed at the time, da	use(s) and manner as te and place, and due	s stated.  to the cause(s)
To th To th comp	Me	29b. Signature and title of certifier	MO		29c. Licensi	number	29	d. Date signed (Mont	h, Day, Year)
1		30. Name and address of person with the street of the stre	ed cause of death (Item	23a) (Type, I	Print)	#41	Merille	M 2109	3
Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Signatu	ure .		., ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	<u> </u>		
Registr	_	30. Name and address of person  W. I (1.6. She nfm.)  31. Date filed (Month, Day, Year)  MAR 1 5 2006	Alleger s	S A	one fee				

DHMH 17 Rev 1/2001

			1 - For State Registrar	State of Mary		artment of F rtificate of			iene	5 07837
	Discosia:		1. Decedent's Name (First, Middle, La	ist)				2. Date of Deat Month		3. Time of Death
	Physici /Medic		Elizabeth Mar						12, 200	
	Examin	er	4a. Facility Name (If not institution, give				r Location of Death		4c. County of	
			Charlestown Ca				Sville	1	Balti	
	Funeral Director			Sex 7. Age (li 1  M 2	n yrs. last birthday) Yrs.	Months Days	Hours Min.	(Month, Day,	Year)	Birthplace (State or Foreign Country)
			Usual Residence of Decedent		80		1	Aug. 18	1925	Pennsylvania
	yland		10a. State 10b. County	10	c. City, Town or Lo	cation				10d. Inside City Limits
	a-fs	ctor	Maryland Howard	d	Columb:	ia				1 □ Yes 2 X No
	death with the Maryland ms 23a or 28a-f show froust be notified at	Directo	10e. Street and Number			10f. Zip Code		1	0g. Citizen of W	hat Country?
	23a		5565 Vantage Poi	nt Road		21044		U	SA	
	er de	Funeral	11. Marital Status	12. Was Decedent Eve Armed Forces?	r in U.S. 13.	Was Decedent of H If Yes, specify Cub	lispanic Origin? (Sp an, Mexican, Puerto	pecify Yes or No- Rican, etc.)		- American Indian, r, White, etc.
50	rs aft	by F	1 ☐ Never Married 2 ☐ Married 3 🖾 Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:		1 ☐ Yes 2 🔀 No	Specify:		Specify:	White
ş	2 hou	ted	15. Decedent's E	ducation	16a. Dece	dent's Usual Occup	pation		16b. Kind of Bus	siness/Industry
21213-0030	nn 7	pie	(Specify only highest gri	ade completed)  College (1-4or 5+)	(Give	kind of work done DO NOT use retire	during most of work d)	kina		Security
7	giene giene er th	Completed	12	Ounded (1 401 01)	Cla:	ims Exami	ner.		Administ	•
yland	2 should be filed within 72 hours after death with the Marylan and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f show aumatic event, the Madical Examinar crisial be notified at	Be (	17. Father's Name (First, Middle, Last	")			18. Mother's Nam			a)
<u>z</u>	Ment Ment arka	ဥ	John Solomon				Sus	san Hudal	k	
Z	and and is m		19a. Informant's Name/Relationship			_	and Number or Rui			
บ์ บ	ges 1 and 2 should t of Heatth and Men if item 27 is marks or other traumatic		David J. Austin  20a. Method of Disposition	Son			Point Roa			21044 City or Town, State
saltimore,	ages nt of t: if it		1 X Burial 2 ☐ Cremation 3 [	Juenoval nom State	20b. Place of Dispo cemetery, crei		1			
	artme ortan		* 4 □ Donation 5 □ Other (Speci 21. Signature of Funeral Service Lice		New Cathe	Name and Addre	ss of FacilitS tel	//2006 Ba	altimore	e, Maryland
Ö	permit. Pages 1 and 2 Department of Health a Important: if item 27 is any Injury or other tra		> debece	2 45	F	uneral H	ome of Ca	tonsvill	e, Inc.	nwab Witzke e, MD 21228
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the	death. Do not ent	er the mode of dyir	ng, such as cardiac	or respiratory arre	est,	Approximate
	Physician		Immediate Cause (Final	one cause on each line.	Den	nentro	À			Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	aDue to (or as a co	-					
	Examiner		Sequentially list conditions	b						
J	pa iii	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a co	onsequence of);					
(	and Ptran	xam	that initiated events resulting in death) Last	cDue to (or as a co	onsequence of):				-	
8/00,	The faw requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	aiE								
00	ficate p physis the	edicai		d						
×	leath certific attending p I for use as	N/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of p		3-			23d. Date	of delivery
Ω.	death e atte	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 Live birth 2 4 Pregnant at time		]Ectopic pregnancy ] Other ( <i>specify</i> ) _	/		Mon	· ·
5	that the de led by the a detached f	Physician/M	9 Unknown	9□ Unknown						
ń	w requires that the s been signed by to should be detach	þ	Part II. Other significant conditions	contributing to death but n	ot resulting in the u	nderlying cause giv	en in Part I.			bute to the cause of death?
cords,	sen s	ompleted						1 \( \text{Y} \)	s 2 No	3 Probably 4 Onknown
e C	a faw	nple						24a. Was a autops	n 24b. W	fere autopsy findings available nor to completion of cause of
		Cor						perform 1 ☐ Yes 2	ned? de	eath? ☐ Yes 2☐ No
VII.	Physician: The far this certificate has ral director, page 2	Be	25. Was case referred to medical examiner?	Hospital:		oth	or	th (Check only on		
5	Phys r this ral di	1	1 Yes 2 No 27. Manner of Death	1 ☐ Inpatient	2 ER/Outpatier	IL 3LI DOA	Nursing no	ome 5 Reside		
5	ding th. After	tion	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigatio	(Month, Day Ye	ear) Injury	Wor	k? Yes 2 □ No	200. 50001150110	m injury occurre	
UNISION	Atter r dea ector by the	ertification;	3 Suicide 6 Could not b	28e. Place of Injury	- At home, farm, str	eet, factory, office		28f. Location (St	reet and Numbe	or or Rural Route Number,
5	s afte	Cert	4   Hornicide	building, etc. (S	эрөспу)			City or Towr	, State)	
	To the Hospital or Attending Phywithin 24 hours after death. To the Funeral Director: After this completely filled in by the funeral		29a. Certifier .1 Certifying Pl	hysician: To the best of miner: On the basis of ex	ny knowledge, death	n occurred at the tir	ne, date and place,	and due to the ca	ause(s) and man	nner as stated.
	the H hin 24 the F nplete	Medical	one)	and manner stated	·					
	To vitè co⊓	2	29b. Signature and title of certifier	mb		29c. Licens	e number		7 - 1	(Month, Day, Year)
	7		1/2			PU	1771	- //	VIACK	1), 2006
	10		30. Name and address of person who	completed cause of death	G VO	Print) a ton!	sville	Mars	and ?	13, 2006
	Sta	ite	31. Date filed (Month, Day, Year)	3/ Registrar's		M 0		J		
	Registr		MAD 1 5 20	ING HOLEN	IF ONE					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For Stete Registrat Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** AVERY LLYDE 3:20PM March 10 2006 /Medical 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner Bayview Medical Bal Baltimore Hopkins timore Center Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Y, 3 - 2 - 19 5. Social Security Number 6. Sex 9. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday, **Funeral** 44-46-8140 1 M 2□F Director Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland Heelth and Mental Hygiene. Sem 27 is marked other than \*naturel\*, or items 23a or 28s-f ehow 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits r 28a-f ehow BAltimorE 1 Yes 2 □ No Completed by Funeral Director 10e. Street and Numbe 10f. Zip Code 10g. Citizen ol Whal Country? r than "naturel", or Itema 23a or the Medical Examiner must be r SA Woon 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 II No If Yes, Give . Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status White, etc. 1 ☐ Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify. 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedenl's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) OWNER treumetic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Be William 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) AUE BAItO MD Heelth tsm 27 WOOD Itsm 27 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 5 = 5 BAltimore 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Department of Important: If eny injury or once. 3-18-2006 M+ CARMEI 21. Signature of Funeral Service Licenses 22. Name and Address of Facility BA 140 mo 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. E. DI.VECST Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Cardiac **Physician** Arrest /Medical Examiner Hypoxia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Be Completed by Physiclan/Medical Examiner Due to (or as a confequence of): ending physicien and use as the burial-transit Hospitel or Attending Physician: The law requires that the death certificate be executed Assiration Preumonia Due to (or as a nsequence of): Box 68760 IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time ol death 5 Other (specify) P.O. signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did lobacco use contribute to the cause of death? Division of Vital Records. 3 Probably 4 Dunknown 1 ☐ Yes 2 ☐ No 24a. Was an 24b. Were aulopsy findings available prior to completion of cause ol death?

1 Yes 2 No 2 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death | Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient ٩ 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Dale of Injury (Month, Day Year) 28b. Time of 28c. 28d. Describe how injury occurred Medical Certification: t Natural 5 Pending efter death.

Director: After in by the fun 2 No 1 Tes investigation 2 Accident n 24 hours efter deg he Funerel Directo roletely filled in by th 6 Could not be determined 3 ☐ Suicide 28e. Place ol Injury - At home, farm, street, lactory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely (Check only one) To the within 2. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2 March 10 Re5-000 Thysician Kesident

State Registrar ٍ 4940 Eastern

hameje

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Johns Hopkins Bayview Medical center

Richard J. Burrello 06-00928 AKG

**Funeral** 

Director

the Medical Experimenment by motified at

or Iteme 23a

"natural"

Hygiene.

Be

permit. Pages 1 and 2 should be filed w Department of Heelih and Mental Hygier Important: If Item 27 is marked other th any Injury or other traumatic event, that once.

**Physician** 

/Medical

Examiner

attending physiclen and for use es the burial-transit

signed by the atte

page 2

Attending Physician: The law requires thet the death certificate be executed

Records, P.O. Box 68760.

of Vital

Division

Examiner

Completed by Physician/Medical

Be

Certification:

with the Maryland

within 72 hours after

Maryland 21215-0036

Baltimore,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Unpend item# 23a, PII. 27, pen/e 0853, 3/27/06 IT State of Maryland Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) February 6, 2006 Physician 8:11 A M Richard J. Burrello /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Temple Hills Prince George's 2405 Gaither Street If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) , 19 46 Washington 5. Social Security Number 7. Age (In yrs. last birthday) 59 Yrs. <u>1</u>X□XM 2□F 577-62-5163 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County MD 1 Yes 2 No Prince Georges **Funeral Director** Temple Hills 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 2405 Gaither Street 20745 United States 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Maritat Status 1 X Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married 1 ☐ Yes 2/□No Specify: Specify: Black Completed by 1968 3 ☐ Widowed 4 ☐ Divorced

15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Army Serviceman

16b. Kind of Business/Industry Military

8 17. Father's Name (First, Middle, Last) Gary Zeno Burrello

18. Mother's Name (First, Middle, Maiden Sumame) Thelma Proctor

19a. Informant's Name/Relationship (Type, Print) Thelma Burrello Scott-Mother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2405 Gaither St., Temple Hills, MD20745

20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition NBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Arlington Cemetery 2/21/2006 Arlington, VA

21. Signature of Funeral Service Licenses oanna 23a. Part / Enter the disease, or complications that ceused the death, bo not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

22. Name and Address of Facility Blount Funeral Service 1632 Crittenden St., NE Wash., DC20017 22. Name and Address of Facility

Immediate Cause (Final disease or condition resulting in death)

Hypertensive cardiuovascular disease Due to (or as a consequence of):

Approximate Intervat Between Onset and Death

Year

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Que to (or as a consequence of).

Due to (or as a consequence of)

23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown

23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 4 Pregnant at time of death

9 Unknown

3 Ectopic pregnancy 5 Other (specify)

23d. Date of delivery Month Day

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

Mitral insufficiency, lipomatous hypertrophy of interatrial septum

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown

24b. Were autopsy findings available prior to completion of cause of death?

autopsy performed? 1 XYes 2 □ No 26. Place of Death /Check only one

XYes 2□ No

25. Was case referred to medical XXYes 2 □ No

27. Manner of Death 5 Pending investigation 2 Accident

6 Could not be determined

1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of

28c. Injury at Work? 1 Yes 2 No

Other: 4 Nursing Home 5 Residence 6XXX ther (Specify) at Scene 28d. Describe how injury occurred

235 Cartifier (Check only one)

3 Suicide

4 Homicide

1 Certifying Physician: To the best of my knowledge death occurred at the time, date and place, and due to the cause(s) and in anner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

mi

29c. License number O.C.M.E.

29d. Date signed (Month, Day, Year) February 7, 2006

28l. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date liled (Month, Day, Year)

MAR 1 5 2006

32 Registrar's Signature

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

DHMH 17 Rev 1/2001

To the Hospital or Attanding Phywithin 24 hours after death.
To the Funeral Director: After thi completely filled in by the funeral of

			For Stata Registrar	State of Maryland	Department of Healt Certificate of Dea		tal Hygier	/ HIII	07840
i	Physici /Medic	_	1. Decedent's Name (First, Middle, Last	e Brou	M	a !	Date of Death Month	13 200 to	3. Time of Death 8-27A M
	Examin  - Funeral  Director	100	4a. Facility Name (If not institution, give GOOD SAMA-R 5. Social Security Number 6, Se 120 - 14 - 9397	ITAN HOSPIT	- T	HORE nder 24 Hrs. 8. purs Min	Date of Birth Month, Day, Ye ARCH 29	4c. County of Death    V	A- lace (State or Foreign http:) RVLAND
	e Maryland	etor	Usual Residence of Decedent  10a. State 10b. County  MARYLAND N	10c. City, To	own or Location BALTI		CITY		0d. Inside City Limits 1 12 Ves 2 □ No
36	itied within 72 hours after death with the Maryland Hygiene. wher then "natural", or Iteme 23a or 28a-f show int, the Medical Examinar must be multibud	by Funeral Director	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	ELVEDERE F  12. Was Decedent Ever in U.S. Armed Forces? 1 M Yes 2 □ No If Yes, Give Year or Dates:	10f. Zip Code  2  13. Was Decedent of Hispanic If Yes, specify Cuban, Me:  1 □ Yes 2 ⋈ No Spe	xican, Puerto Rica	Yes or No-	14. Race - Americ Black, White,	an Indian,
d 21215-0036		Completed	(Specify only highest grade  Elementary/Secondary (0-12)  The RADE  17. Father's Name (First, Middle, Last)	cation 1 e completed)  College (1-4or 5+)	6a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired)  FFICE SUPPLY STOP  18. M		GER OF		
Maryland	should be and Mental is marked o	To Be	GEORGE  19a. Informant's Name/Relationship (7)	O BA	ROWN SR /- 9b. Mailing Address (Street and No	RUTH umber or Rural Ro	ute Number, Ci	CALLO ty or Town, State, Zip	
	Pages 1 end 2 in the second of the second of Health are second or the se		MURIEL SUGGS  20a. Method of Disposition  1 Burial 2 Cremation 3 F	Removal from State 20b. Place	of Disposition (Name of othery, crematory or other place)	Date	20c	Location City or To	
Baltimore,	permit. Pag Department Important: t any Injury o once.		4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service Licens	1. William	3UTUS CEMETER 22. Name and Address of 2140 N. FU	A. BRO	WE. BA.	LIO, MD.	21217
	Physician /Medical Examiner	ner	23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	ications that caused the death. In e cause on each line.  Due to (or as a consequent)  Due to (or as a consequent)	Plyo Cardia	xl gm	AME	tion	Approximate interval Between Onset and Deptih
68760,	ficate be executed physicien and s the burial-transit	edicai Examiner	Cause (Disease or injury	c	ce of):				
P.O. Box (	The law requires that the death certificate has been signed by the attending page 2 should be detached for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal de 4 □ Pregnant at time of death 9 □ Unknown	ath 3 ☐ Ectopic pregnancy			23d. Date of delive Month	ery Day Year
	quires that in signed b uld be deta	by	Part II. Other significant conditions co	ntributing to death but not resultin	g in the underlying cause given in F	Part I.	23e. Did tobace 1 ☐ Yes	co use contribute to t	10
Vital Records,		Completed					24a. Was an autopsy performed 1 Yes 2 🗸	prior to co	ppsy findings available impletion of cause of 2 XI No
	nysiciai nis certif directo	To Be	25. Was case referred to medical examiner?  1  Yes 2 XNo	Hospital: 1 ☐ Inpatient 2 ER	Othor	Place of Death [Cl		e 6 □Other (Specia	(y)
Division of	Attending Physician: r death. ector: After this certifice by the funeral director. p	ertification;	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28a. Date of Injury (Month, Day Year) 28 28e. Place of Injury - At home	b. Time of Injury Mork?  M 28c. Injury at Work?  1 □ Yes	2 □No	Describe how i	njury occurred t and Number or Run	al Route Number
Δ	2 2 2 2	O	4 Homicide determined	building, etc. (Specify)			City or Town, S	tate)	
	To the Hospital or Attenwihin 24 hours after deatl To the Funeral Director: completely filled in by the	edical			dge, death occurred at the time, da and/or investigation, in my opinion				
)	T T T T T T T T T T T T T T T T T T T	Σ	29b. Signature and title of certifier	inguare	29c. License num D30	66	M	Date signed (Month,	poy ( Year) 2000
1	110		30. Name and address of person who g	ompleted cause of death (Item 23	a (Type, Print Balti 1	iole.	rd-	2123	9
	Sta Regist		31. Date liled (Month, Day, Year) 2	32. Registrar's Signature	Acoust .				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. item# 17, 18, perInf .854, 4/21/06 TT State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No.-1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 03 **Physician** 12<sup>Day</sup> 2006ar Marcelina Antonia Bazzano 10:10a <sup>™</sup> /Medical 4a. Fecility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Washington Adventist Hospital Montgomery Takoma Park If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 85 Yrs 6. Sex 8. Date of Birth (Month, Day, Yeer) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 1 □ M 21 F Yrs. Director 219-82-6343 08-24-1920 Argentina Usual Residence of Decedent filed within 72 hours after deeth with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28e-f ehow r then "natural", or iteme 23a or 28e-f ehor the Medical Examinar must be notified at MD Prince George Adelphi 1 Yes 2 No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9527 Riggs Rd. 20783 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2x ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 x Yes 2 No Specify: Argentina White Ď 35€3tWidowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Sumame 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if Item 27 is marked oth any linjury or other traumatic event 2002. Hector Balbuena Rufina Unavailable Rufina Fernandez Unavailable Balbuena 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marta Hidalgo/daughter 9527 Riggs Rd. Adelphi MD 20783 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition Cedar HIII Cemetery 03-15-2006 1 

Burial 2 □ Cremation 3 □ Removal from State Suitland MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Rapp Funeral & Cremation Service
933 Gist Av Silver Spring MD 20910 ma135 8 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician a Atherosclerotic Cardiovascular Disease /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner be executed use as the burial-transit Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d, Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ete has been signed by the atterpage 2 should be detached for it in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4☐ Pregnant at time of death 5 Other (specify) Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۵ 1 Yes 2 No 3 Probably 4 CLInknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 ☐ Yes 2(2X)No Division of Vital To the Hospital or Attending Physicien: within 24 hours after death.

To the Funerel Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 XInpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 2 ER/Outpatient 3□ DOA 27. Manner of Death Date of Injury (Month, Day Yeer) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature nd title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

9

State Registrar Darcie M. Hammer 1300 Piccard Dr. Ste 202 Rockville MD 20850

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year) MAR 1 5

MD60319

03-13-2006

	89
	Box
BAHR	P.O.
ANNABELL	Division of Vital Records, P.O. Box 68

		For State Registrar	Please			l / Depa		lealth and	Mental Hyg	Are Legible.	07842
Physici /Medic		1. Decedent's Nar	me (First, Middle, Las e Veronica							11, 2006 Year	3. Time of Death 5:30 AM M
Examin	er	Stella 1	(If not institution, give Maris Hosp	oice				Timonium		4c. County of Dea Baltimor	e
Funeral Director		5. Social Security 219-18-4	4138	ex 7. Ac ☐ M 25€F	ge (In yrs. Ia 82	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min		9. Bir 1924	thplace (State or Foreign ountry)
Aaryland Febow	or	Usual Residence 10a, State MD	10b. County  Baltimo	re		Town or Lo	cation	iiim			10d. Inside City Limits
with the A a or 28a-i	Director	10e. Street and N					10f. Zip Code 21093			10g. Citizen of What C	ŕ
permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Heelth and Mental Hygiene. Important: If time 27 is marked other then "natural", or items 23a or 28a-f show eny injury or other traumatic event, it is Medical Examinant to notified at once.	by Funeral	11. Marital Status		12. Was Decedent Armed Forces 1Yes _2 If Yes, Give Year or Dates:	? HNO			dispanic Origin? (s an, Mexican, Puer Specify:	Specify Yes or No- to Rican, etc.)	14. Race - Ame Black, Whi	erican Indian, te, etc.
ad within 72 hours aft giene. er then "neturel", or the Medical Exercit	Completed	(Spe	15. Decedent's Ececify only highest gra	ducation de completed) College (1-4or	5+)	(Give life. l	dent's Usual Occup kind of work done DO NOT use retire	during most of wa	rking	16b. Kind of Business Own Home	
uid be filed w fental Hygier rked other th	To Be Cor		(First, Middle, Last) Michael			Homen	aker		me (First, Middle, Griffin	Maiden Sumame)	
y IVICITY CONTROLL  and 2 should be file bith and Mental Hy 127 is marked oth or traumatic event			Name/Relationship ( Bahr/Grands				ng Address <i>(Street</i> S. Atlaı			r, City or Town, State, .706 Dayton	Zip Code) la Beach, FL
Dallimore, Sernit. Pages 1 ar Department of Hee Important: if item sny injury or othe			isposition  2		cer	metery, cren	sition (Name of matory or other pla ke Crema		Mar 14 2006	20c. Location - City or Beltsville,	
Dall permit. Departr importr eny inji		21. Signature of F	Funeral Service Licer	itta Ma	1443				al Alterna Drive Ba	atives altimore, Ma	aryland
Physician //Medicale be executed be provided and physician and as the burial-transit	icai Examiner	Immediate Cause disease or condition resulting in death sequentially list of any, leading to cause. Enter Uncause (Disease of that initiated ever resulting in death	conditions, immediate derlying or injury	b. Due to (or as Due to (or a)	s a conseque	ence of):	CCIDENT				Onset and Death
the death cert the attendin	Physician/Medical	IF FEMALE: 23b. Was deceded in the past 1 1 □ Yes 2 9 □ Unknow	2 months?	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a	2 Fetal c	death 3	Ectopic pregnanc Other (specify)	у		23d. Date of de Month	livery Day Year
quires that to signed by uld be dete	۵	Part II. Other sign	nificant conditions o	ontributing to death I	but not result	ting in the u	nderlying cause gn	ven in Part I.		bacco use contribute l es 2 □ No 3 □ P	o the cause of death?
	Completed								24a. Was a autop: perfor 1 🗆 Yes	med? death?	utopsy findings available completion of cause of
for Attending Physician: The affect death. Director: After this centificate he in by the funeral director, page	Certification: To Be	25. Was case refrexaminer?  1  Yes 2 2  27. Manner of De  1 Natural 2  Accident 3  Suicide	X No ath 5 ☐ Pending investigation 6 ☐ Could not b	28a. Date of Inj (Month, Da		28b. Time of Injury	28c. Inju	ner: 4 🗆 Nursing I	28d. Describe h	ence 6 NOther (Specow injury occurred	HODI TOD
To the Hospital or Attending Phy within 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral		4 Homicide  29a. Certifier (Check only	1X Certifying Ph	building, e	t of my know	ledge, deati	occurred at the ti		e, and due to the c	ause(s) and manner a	s stated.
To the P within 24 To the F complete	Medical	29b. Signature ar	nd title of certifier	and manner s	tated.		29c. Licen:		2	29d. Date signed (Mon 3 // 3 /	th, Day, Year)
1		DR. TA	dress of person who	DD 2300 I	DULANE	Y VALI	Print)  LEY RD.	TIMONIUM	I, MD 210		
Sta Registr		31. Date filed (Mo	MAR 1 5	2006 32. <b>Regist</b>	trar's Signatu	J. A	ande				

			1 = For State Registrar	State of M	arylan	•	artment rtificate			ınd Me	,	giene	nna	07843
		-	1. Decedent's Name (First, Middle, La	ast)						2	Date of Dea Month			3. Time of Death
	Physici	3	John A. Bishop								March	6. Da	2006	5:00 A.
1 2	/Medic Examin		4a. Facility Name (If not institution, gir				4b. City,	Town, or	Location of				. County of Death	
	- LACINIII		Annapolis Nursi	ng & Rehab			A <sub>1</sub>	nnap	olis				Anne A	rundel
	Funeral					last birthday)	If Under	1 Year	If Under 2		Date of Birt	h .		pplace (State or Foreign untry)
	Director		218-09-5560	1₩ M 2□F	96	Yrs.	Months	Days	Hours	Min.	(Month, Day an. 15			yland
			Usual Residence of Decedent		20		1			υc	111. 17	, I.	olo Hai	yrand
	yland Mow		10a. State 10b. County		10c. Cit	y, Town or Lo	cation							10d. Inside City Limits
	Man Man	ţo	Maryland Baltimo	ra	Ra.	ltimor	2							1 ☐ Yes 2 ☑ No
	the 28s	Funeral Director	10e. Street and Number	1.6		r'e rmor (	10f. Zip	Code				10g. Ci	itizen of What Cou	untry?
	with w	ā	620 Harradala Dani				2.1	1229					77.0.4	
	eath	era	620 Warwick Road  11. Marital Status	12. Was Decedent	Ever in U	S 13.1			snanic Orio	nin? (Specif	v Yes or No-		USA 14. Race - Amer	ican Indian
	in the diameter of the diamete	ä	1 Never Married 2 Married	Armed Forces?			If Yes, spec	rfy Cuba	n, Mexican	, Puerto Rio	y Yes or No- an, etc.)		Black, White	
36	rs at	by F	3 Widowed 4 Divorced	If Yes, Give Year or Dates:	ww]	гт	1 ☐ Yes 2	2⊠ No	Specify:				Specify:	White
21215-0036	72 hours after death with the Maryland Insturat', or itema 23s or 28s-1 show disal Examination to Institled at	B	15. Decedent's E		*****		dent's Usua	d Occupa	ation			16h k	(ind of Business/I	ndustry
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12	within ene. than "	Ē	Elementary/Secondary (0-12)	College (1-4or	5+)		nker		,				Banking	
	Hygie Hygie other		17. Father's Name (First, Middle, Las	(t)			IIICI		18. Mother	r's Name (F	irst, Middle,			
JU.	2 should be filed within and Mental Hygiene. Is marked other than aumatic event, the Mental aumatic event, the Mental aumatic event.	Be	Unknown	•/						known				
Ž	Mer Merke Marke	2						/=: :				0.		
Maryland	2 sh and is m		19a. Informant's Name/Relationship	(Type, Print)		19b. Mailir	ng Address	(Street a	and Numbe	r or Rural F	loute Numbe	r, City	or Town, State, Z	îp Code)
	1 and Health iem 27 other tr		Thomas Homans	Friend	1				Road;				ryland 2	
ST.	of H of H fiter		20a. Method of Disposition 1  Burial 2  Cremation 3 (	□ Removal from State	C	lace of Dispo emetery, crei	matory or of	ther plac		Dat			ocation - City or	
Ĕ	Pages nent of int: if its iry or o		4 □Donation 5 □Other (Spec		Crov	vnsvil	le Cen	nete	ry 3	/9/20	06	Cro	wnsville	, Maryland
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Menial Hygiene. Department of Health and Menial Hygiene. Important: if item 27 is marked other than "natural", or itema 23a or 28a-1 show air injury or other traumatic event, the Madical Examiner must be nutitied at once.		21. Signature of Funeral Service Lice	erisee	1111	22	2. Name and	d Addres	s of Facility	Ster.	ling A	sht	on Schwa	b Witzke
m	Depa Impo any ir		1/mie	111		16	Funera 630 Ea	al H	ome o	i Cat	onsvil e: Cat	le,	Inc. ville, M	m 21228
	*		23a. Part 1. Enter the disease, or cor	mplications that cause	d the deat								VIIIC, 1.	Approximate
			shock, or heart failure. List only Immediate Cause (Final			Dar	( )	n.						Interval Between Onsel and Death
p. 16	Physician /Medical		disease or condition resulting in death)	" CODOH	-	HOZ	End	NA	KASL					
	Examiner			Due to (or as	a conseq	1 000								
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9	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE:											
Box	th ce rendi	an/l	23b. Was decedent pregnant	23c. If yes, outcome 1 ☐ Live birth			□Ectopic pre	egnancy				-	23d. Date of deli	,
H	the at	Sici	in the past 12 months? 1 ☐ Yes 2 ☐ No	4□Pregnant a 9□ Unknown	t time of d		Other (spe						Month	Day Year
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	res that signed to be det	ру Р	Part II. Other significant conditions	contributing to death t	ut not res	ulting in the u	nderlying ca	ause give	en in Part I.		23e. Did to	bacco	use contribute to	the cause of death?
ğ	n sig	Ď T									1 □ Y	es 2	!□No 3□Pro	obably 4 Unknown
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a	ding Physician: The taw h. After this certificate has t funeral director, page 2 s			1								2 N	o 1 ☐ Yes	2□ No
Vital	Physician: this certificatal director, i	Be	25. Was case referred to medical examiner?	Hospital:				Cth	25.		Check only o			
of	this al dir	2	1 Yes 2 No	1 Inpati		ER/Outpatier		JA	4 XIVUI				6 □Other (Spec	offy)
Ē	ing F	Certification:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	y Year)	28b. Time o Injury		8c. Injun Worl		1	d. Describe h	iow inju	iry occurred	
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Ξ	or Att	Ē	4 Homicide determined	28e. Place of In building, e	ury - At he tc. (Specif	ome, farm, sti y)	reet, factory	, office		281	Location (S City or Tow	Street a vn, Stat	nd Number or Ru 'e)	ral Route Number,
	To the Hospital or Attent within 24 hours after deatl To the Funeral Director: completely filled in by the	Ce												
	Hospital Hospital Funeral Tely filled	cai	29a. Certifier Certifying P	hysicien: To the best minar: On the basis of	of my kno	wledge, deat	h occurred	at the tim	ne, date and	d place, and	due to the	cause(s	s) and manner as	stated.
	he H n 24 he F piete	Medical	one)	and manner st	ated.	Mon and or in	vestigation,	, iii iiiy o	piritori, dear	III OCCUITED	at the time, t	uate an	o piace, and due	(() (i)e cause(s)
	To the within 2 To the complet	Σ	29b. Signature and title of certifier			1 1	290	. License	number			29d. Da	ate signed (Monti	n, Day, Year)
			At. I	V- W	ann	J. W.	)	11,	MILL			3	18/61	
	11.		30. Name and address of person who	completed cause of	death (Iten	n 23a) (Type.	Print)	<u> </u>	2	3			10/00	
	17		1406 S.CR	SH Him	HIN	AT	CIL	143	SNR	3itt	MD	2	1061	
1	Sta	te	31. Date filed (Month, Day, Year)	32. Regist	rar's Signa	iture			,	.1 . L	•		1-0.	
	Regist		MAR 1 5 20	106	A.	Are	offe B							

DHMH 17 Rev 1/2001

			1 - For State Registrar	State of Maryla		artment of rtificate o			Reg. No. 1) () (	07844
	Physici	an	1. Decedent's Name (First, Middle, Last					2. Date of De Month	Day Year	3. Time of Death
	/Medic			arbakos				March	8 2006	6:25p M
	Examin	er	4a. Facility Name (If not institution, give Mariner Healt			Laur	n, or Location o	i Death	4c. County of De	Georges
3	3		5. Social Security Number 6. Se		s. last birthday)	If Under 1 Ye			th 9.B	irtholace (State or Foreign
	<ul><li>Funeral</li><li>Director</li></ul>				84 Yrs.	Months Day		Min. (Month, Da	0,1921 Ne	W Jersey
16.	D		Usual Residence of Decedent			1		1000.0		
	show	_	10a. State 10b. County		City, Town or Lo					10d. Inside City Limits 1 ☐ Yes 2 🔀 No
	Ba-f	cto	Md Howard		Elkrid				40 000 - 400	
	with the	ä	10e. Street and Number			10f. Zip Cod	1075		10g. Citizen of What (	country?
	be filed within 72 hours after death with the Maryland tal Hygjene. d other then "naturel", or Iteme 23a or 28a-f show event, the Medical Examination that hudfiled at	Funeral Director	6609 Pirch Way	12. Was Decedent Ever in	U.S. 13.			gin? (Specify Yes or No		nerican Indian,
10	r Iten	표	1 □ Never Married 2 □ Married	Armed Forces? 1 ☐ Yes 2 ☑ No				gin? (Specify Yes or No , Puerto Rican, etc.)		
036	el', o	þ	3 Midowed 4 Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 ☐ 📉	No Specify:		Specify:Wh	ite
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2	e filed within al Hygiene. other than '		12th 17. Father's Name (First, Middle, Last)		ПОШ	emaker		r's Name (First, Middle	1	
and	lid be f lental h rked of	Be c	Charles J. Ly	ong				a Renear	,,	
Maryland	s 1 and 2 should be I Health and Menta tem 27 Is marked other traumatic ev	2	19a. Informant's Name/Relationship (7)		19b. Maili	ng Address (Stre			per, City or Town, State	, Zip Code)
<u>≅</u>	and 2 sealth ar n 27 is		Linda Link / d		402	Braxt	on Cou	ırt Joppa	MD 21085	
ē	Item 2		20a. Method of Disposition	206	. Place of Dispo	osition (Name of	place)	Date	20c. Location - City	
Ë			1 Burial 2 ☐ Cremation 3 ☐ 6 4 ☐ Donation 5 ☐ Other (Specify,	Removal from State	ak Law	n Ceme	tery	3/13/06	Baltimo	re MD
Baltimore,	permit. Page Department of Important: If eny Injury or once.		21. Signature of Funeral Service Licens	ee anne	Co	2. Name and Adonnell	dress of Facility  Fune	y 300 Maceral Home	e Ave. Ba of Essex	lto. MD 21221
			23a. Part 1. Enter the disease, or eamp shock, or heart failure. List only o	lications that caused the de	eath, bo not en	ter the mode of	dying, such as	cardiac or respiratory a	arrest,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition		CTED	DECH	BITUS	GLCE,	8 -	Mow Trs
1	/Medical		resulting in death)	Due to (or as a cons					`	
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. 10	po ji	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a cons	equence of):					
( 80	and I-tran	Examiner	that initiated events resulting in death) Last	c Due to (or as a cons	equence of):					
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687	ficate physis the	adic		d						
Box (	eath certifica attending phi for use as th	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pre-		Je 61 . 65			23d. Date of c	delivery
m	death e atte	icia	in the past 12 months? 1 ☐ Yes 2 Q No	1 Live birth 2 ☐ F 4 ☐ Pregnant at time of		□Ectopic pregna □ Other ( <i>specify</i>			Month	Day Year
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	res tha igned l	by F	Part II. Other significant conditions co		•	, ,	given in Part I.		tobacco use contribute	
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= B	The i	S						pert 1 ☐ Yes	ormed? death 2/5No 1 ☐ Y	
/ita	ician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	Ho exital:				of Death Check only		
of	Physic this c	7	1 ☐ Yes 2 No  27. Manner of Death		ER/Outpatie				idence 6 Other (S)	pecify)
uc		tion	1 Sanaturaf 5 ☐ Pending	28a. Date of Injury (Month, Day Year	) Injury		njury at Work? 1 ☐ Yes 2 ☐		now injury occurred	
Division	Atten deat ctor: y the	fica	3 Suicide 6 Could not be	28e. Place of Injury - A	t home, farm, st			28f. Location	(Street and Number or	Rural Route Number,
2	after after I Direct	Certification:	4  Homicide determined	building, etc. (Spe	ecify)			City or To	own, State)	
	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: Afte completely filled in by the fune	Medical C		rsician: To the best of my liner: On the basis of exam and manner stated.						
	Fo the Fo the compl	Me	29b. Signature and title of certifier	0			ense number		29d. Date signed (Mo	
	, , , , , ,		1 Pritam	4			0289	899	MARCH 1	0,2006
	2		30. Name and address of person who o	ompleted cause of death (I	tem 23a) (Type	Print) PR	ITAM	5 SAIM	, MD	
	C		30. Name and address of person who of a contract of the contra	LANE SUIT	E 211	LAL	PREL	MD 2	0708	
	Sta Regist		31. Date filed (Month, Day, Year) MAR 1 5 2006	32. Registrar's Si	gnature	E				

DHMH 17 Rev 1/2001

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			For State Registrar		State of M	-	•	rtment of F tificate of	Health and N <i>Death</i>	-	giene Reg. No.	UUb	07845
	Physici	an		e (First, Middle, Las	Girl-Boor	<del>ie</del> Dan	iva	Marshay	Perry	2. Date of De Month	Day		3. Time of Death
	/Medic Examin	al	4a. Facility Name (		street and number)	1			or Location of Death	March		2000 County of Death	
	Funeral		The John 5. Social Security N		Kins Hosp	)Ital je (In yrs. last bir	thday)	If Under 1 Year		Date of Bir	th	NA 9. Birth	place (State or Foreign
	Director		NA Usual Residence o		□M 2 <b>X</b> )F		Yrs.	Months Days	Hours Min.	(Month, Da 3-9-(	1 <i>y, Year)</i> 06	Cou	Md.
	iryland show	* 10/1	10a. State	10b. County NA		10c. City, Town		cation nore					10d. Inside City Limits 1 X Yes 2 ☐ No
	28a-f	Director	10e. Street and Nu					10f. Zip Code			10g. Citiz	zen of What Cou	
	ath with	raiD		amrock Ave			.,	21206				USA	
920	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene.  If Item 27 is marked other then "natural", or Iteme 23a or 28a-f show or other traumatic event, the Medical Examinational bandling at	by Funeral	<ul><li>11. Marital Status</li><li>1  Never Marital  Widowed</li></ul>	ried 2 Married	12. Was Decedent Armed Forces:  1  Yes			Vas Decedent of H Yes, specify Cub	Hispanic Origin? (Span, Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)		14. Race - Ameri Black, White, Specify: B	
21215-0036	in 72 ho "natu	Completed by		15. Decedent's Ecify only highest gra	de completed)		(Give I	ent's Usual Occup kind of work done OO NOT use retire	during most of work	ang	16b. Kir	nd of Business/Ir	ndustry
212	filed within Hygiene. Ither then "	Com	Elementary/Seco Infant		College (1-4or	5+)	Infa	ant	1 12			NA	
land	id be fil ental H ked oth Ic even	То Ве	17. Father's Name Danie	(First, Middle, Last) ]	Maurice	]	Peri	v, Jr.	18. Mother's Nam Chanda	e (First, Middle		Boone	
Maryland	2 shour and M		19a. Informant's N	ame/Relationship (	Type, Print) Grandmot	1	_		and Number or Rui		115		
	permit. Pages 1 and 3 Department of Health Important: If Itam 27 eny Injury or other tr. <u>900e</u> .		20a. Method of Dis	position		20b. Place of	f Dispos	sition (Name of latory or other pla		Date		cation - City or T	
Baltimore,	nit. Page eartment of ortant: If Injury or	- 54	4 Donation	5 Other (Specify	and the same of th		Men	n. Park	3-1	5-06		ndallsto	
Bal	Departimon Importential		han	uneral Service Licer	116000	Q	N	Name and Address	H. East	1101	E. N	ore, Md. North Av	21202 e.
	Physician /Medical Examiner		23a. Part / Enter shock, or hea Immediate Cause disease or condition resulting in death)	(Final on	plications that cause one cause on each I	d the death. Do done.  SiS a consequence		or the mode of dyi	ng, such as cardiac	or respiratory a	rrest,		Approximate Interval Between Ofiset and Death
	executed en and rial-transtt	Examiner	Sequentially list co if any, leading to in cause. Enter Und Cause (Disease of that initiated event resulting in death)	S	· PUL	a consequence	1	Many	rac				1 day
68760,	certificate be exiding physicien ise as the buria			l	a Extr	êne -	$\sim$	notry	ify				1 day
P.O. Box	w requires that the death certificate be ex been signed by the attending physicien should be detached for use as the buria	Physician/Medical	IF FEMALE: 23b. Was deceder in the past 1≨ 1 ☐ Yes 2 9 ☐ Unknown	months?	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Fetal death		Ectopic pregnanc Other (specify)	y		2	3d. Date of delive Month	very Day Year
	equires tha en signed l		Part II. Other signi	ficant conditions o	ontributing to death t	out not resulting in	n the un	derlying cause gr	ven in Part I.	23e. Did t	2	1	the cause of death? bably 4 □Unknown
Division of Vital Records,	The lay ate has page 2	Completed by								24a. Was auto perfo 1 Yes		24b. Were autoprior to codeath?	opsy findings available ompletion of cause of No
fVit	Physician: The I this certificate har ral director, page	To Be	25. Was case rele examiner? 1 Tes 2	٩.	Hospital: 1 Inpati	ent 2 ER/Ou	utpatien	3□ DOA Ott	26. Place of Dea her: 4 ☐ Nursing He			G □Other (Speci	ify)
o uo	ding Pt h. After th funeral		27. Manner of Dea 1 Natural 2 ☐ Accident	th 5 Pending investigation	28a. Date of Inj (Month, Da		Time of njury	28c. Inju Wo	ry at ork? ]Yes 2 ☐ No	28d. Describe	how injury	occurred	
Divisi	al or Atten a after deat i Director: d in by the	ertifica	3 Suicide 4 Homicide	6 Could not be determined	e 28e. Place of In	jury - At home, la tc. (Specify)	arm, stre	eet, factory, office		28f. Location ( City or To	Street and wn, State,	d Number or Rur )	ral Route Number,
	To the Hospital or Attending Physic within 24 hours after death.  To the Funeral Director: After this ce completely filled in by the funeral director and the funeral directors.	Medical Certification:	29a. Certifier (Check only one)	1 Certifying Ph 2 Medical Exam	ysicien: To the best priner: On the basis of and manner s	of examination an	e, death	occurred at the ti estigation, in my	ime, date and place, opinion, death occur	and due to the red at the time,	date and	place, and due t	to the cause(s)
	With To 1	Σ	29b. Signature and	d title of certifier	Sell 1	P		29c. Licen	se number 56656		Adv	e signed (Month,	Day, Year)
			30 Name and add	60 B	completed cause of	death (Item 23a)	(Type,	Wolfe S	treet P	sathm	ve.	Manyl	and
	Sta Registi		1,30		006	· · · · · · · ·	A	ande)				1	

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Physician Dealer Seminary use and an another seminary use and and number of the physician physic				for State Registrar	State of N	laryland /	Department of Certificate		d Mental Hy	giene 06	07846
Direction  The Company		/Medic Examin	al	Samuel 4a. Facility Name (If not institution 3930 FLOWER	LEE n, give street and numbe RTON ROA	n A D	4b. City, Tov Balt	imore	March	1 12, 200 4c. County of D	06 4.00 74M eath
Pry striction   Pry strictio	D.	Director		214-54-4416 Usual Residence of Decedent		56	Yrs. Months D		in. Sept. &	ay, Year) 1949 M	aryland
Pry striction   Pry strictio	the Marylar	28a-f show	ector	MD NIA			more	de		10g. Citizen of What	1 Yes 2 No
Pry striction   Pry strictio	36 s after death with	, or items 23a or confiner must be	y Funeral Di	3930 FLOWERTO 11. Marital Status 1 □ Never Married 2 Marri	12. Was Deceder Armed Forces ned 1 7 es 2 [ If Yes, Give	s? ] No	2/20 13. Was Deceden ff Yes, specify	99 of Hispanic Origin? Cuban, Mexican, Pu	(Specify Yes or N erto Rican, etc.)	USA lo- 14. Race - A Black, W	mencan Indian, /hite, etc.
Pry striction   Pry strictio	21215-00 d within 72 hour	giene. sr than "natural the Wedical Ex	completed b	15. Deceden (Specify only highe: Elementary/Secondary (0-12)	t's Education st grade completed)	16a	(Give kind of work of life. DO NOT use r	lone during most of v etired)	-	16b. Kind of Busine	ss/Industry
23a. Part / Entry list disease, in complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, introduced any control of the cause of each line. We cause final resulting in death)  25a. Part / Entry list disease, in complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, introduced any cause final resulting in death)  25a. Part / Entry list disease, in complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, introduced any cause final resulting in death)  25b. Sequentially list conditions.  25c. If yes, outcome of prepnancy in the cause of death of the cause of death o	ryland	d Mental Hyg marked oths matic event,	Be	Aaron Cooper		19	h Mailing Address (S	Lillien	nae Vai	ughn	e Zin Code)
23a. Part / Entry list disease, in complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, introduced any control of the cause of each line. We cause final resulting in death)  25a. Part / Entry list disease, in complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, introduced any cause final resulting in death)  25a. Part / Entry list disease, in complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, introduced any cause final resulting in death)  25b. Sequentially list conditions.  25c. If yes, outcome of prepnancy in the cause of death of the cause of death o	ore, N	nt of Health an : if item 27 is or or other traus		Patricia L. Coc 20a. Method of Disposition 1 Burial 2 Cremation	3 Removal from State	20b. Place	30 Flower of Disposition (Name	rton Rd.	Baltimor	e MD 212 20c. Location - City	or Town, State
Pry Sician (Medical Examiner)    Pry Sician (Medical Examiner)   Property   P	Baltin	Depertmer important any injury once.			//	Garrisi -	22. Name and A	ddress of Facility		9	o.mo alaag
Sequentially list conditions.    The past   Part	//\	Medical		sh ck, a heart faifure. List fmmediate Cause (Final disease or condition	a. heba	tocelle	uar co		liac or respiratory :	arrest,	Interval Between Onset and Death
FFEMALE:   23b. Was deceded the pregnant in the past 12 months?   1   yes   2   No   9   Unknown   1   1   yes   2   No   9   Unknown   23c. If yes, outcome of pregnancy   1   1   yes   2   No   9   Unknown   24b. Was a save referred to medical examiner?   1   yes   2   No   3   Probably   24b. Were autopsy indings available to provide the proposed of proposed to provide the provided of the past 12 months?   23c. If yes, outcome of pregnancy   1   1   yes   2   No   3   Probably   24b. Were autopsy findings available to provide the past 12 months?   24b. Were autopsy findings available to provide the past 12 months?   24b. Were autopsy findings available to provide the past 12 months?   24b. Were autopsy findings available to provide the past 12 months?   24b. Were autopsy findings available to provide the past 12 months?   24b. Were autopsy findings available to provide the past 12 months?   24b. Were autopsy findings available to provide the past 12 months?   24b. Were autopsy findings available to provide the past 12 months?   24b. Were autopsy findings available to provide the past 12 months?   24b. Were autopsy findings available to provide the past 12 months?   24b. Were autopsy findings available to provide the past 12 months?   24b. Were autopsy findings available to provide the past 12 months?   24b. Were autopsy findings available to provide the past 12 months?   24b. Were autopsy findings available to provide the past 12 months?   24b. Were autopsy findings available to provide the past 12 months?   24b. Were autopsy findings available to provide the past 12 months?   24b. Were autopsy findings available to provide the past 12 months?   24b. Were autopsy findings available to provide the past 12 months?   24b. Were autopsy findings available to provide the past 12 months?   24b. Were autopsy findings available to provide the past 12 months?   24b. Were autopsy findings available to provide the past 12 months?   24b. Were autopsy findings available to provide the past 12 months?   24b. Were autopsy	760, Ite be executed	ysicien and ne burial-transit	cal	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	C.						
Continue of the continue of	O. Box 61	y the attending p ched for use as i	ysician/Med	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	1 ☐ Live birth 4 ☐ Pregnant	2 Fetal deat at time of death					,
Natural   2   Accident   3   Suicide   4   Homicide   Specify   Natural   2   Accident   3   Suicide   4   Homicide   Specify   Specif	ords, P.	en signed b		Part II. Other significant condition	ons contributing to death	but not resulting	in the underlying caus	e given in Part I.			
Natural   2   Accident   3   Suicide   4   Homicide   Specify   Natural   2   Accident   3   Suicide   4   Homicide   Specify   Specif	The law re	ficate has be or, page 2 sho		25. Was case reterred to medica				OS Place of F	e auto peri 1 ☐ Yes	opsy prior death	to completion of cause of
1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	n of VIII ng Physicia	fter this cert ineral direct	ဥ	examiner? 1 Tyes 2 No 27. Manner of Death	Hospital: 1 ☐ Inpa		Time of 28c.	Other: 4 Nursing	g Home	sidence 6 Other (5	Specify)
1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Divisio	s after death Il Director: A od in by the f	Sertificat	3 Suicide 6 Could	not be 28e. Pface of						r Rural Route Number,
1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	the Hospit	hin 24 hours the Funers npletely fille		(Check only 2 Medical one)	Examiner: On the basis and manner	of examination a	nd/or investigation, in	my opinion, death or	ace, and due to the ccurred at the time	e, date and place, and	due to the cause(s)
A LO COCO	To	Wit TO CO		Akellen	l VI	August (Item 23a)	celmo D	057931	0	03-14-24	مكات
State Registrar  WAR 1 5 2008  State				Heather D. A	Mannuelix	40 90	20 certan	· Ave. E	sathmere	e, UD 212	99

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1809 CT		For State Registrar	State of M	laryland / D	ера		t of H	ealth a		ental Hy		06	078	47
Physicia /Medic Examine	al	Decedent's Name (First, Middle, La James     James     James     James     James	e street and number		Cre	SSON 4b. City, 1	Town, or	Location of	of Death	2. Date of Dea Month March	13	Year 2006 nty of Death	3. Time of I	Death P <sup>M</sup>
Funeral Director				ge (In yrs. last birth	rs.	Chui If Under Months		Hill If Under: Hours	24 Hrs. Min.	8. Date of Birt (Month, Day 5/12	h	en Anr <sup>9. Birthp</sup> Coun De l	ne's lace (State or try) aware	Foreign
e Maryland 3a-f ehow	ctor	Usual Residence of Decedent  10a. State 10b. County  Delaware Sussex		10c. City, Town		cation							0d. Inside Cit	
ges 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. If firem 271 is marked other then "naturel", or Items 23s or 28s-f show or other traumatic event, the Medical Examinatinative notified at	Funeral Director	10e. Street and Number 613 Seabury Ave 11. Marital Status	12. Was Deceden Armed Forces	?	13. V	10f. Zip	1	9963 spanic Orig	gin? (Spe	ecify Yes or No- Rican, etc.)	USA	of What Coun ace - Americ lack, White,	an Indian,	
od within 72 hours atter giene. er then "naturel", or it. , the Wudical Examin	۾ ا	1 Never Married 2 Married 3 Widowed 4 Divorced  15. Decedent's E (Specify only highest gr	1 XYes 2 If Yes, Give Year or Dates:	No 68-73	1 Deced	Yes 2	No No	Specify:		1	Spec	Business/Inc	e	
d 2 should be filed within the and Mental Hygiene.  77 is marked other then traumatic event, the Mental Hygiene.	Be Completed	Elementary/Secondary (0-12)  17. Father's Name (First, Middle, Last	Cotlege (1-4or	5+)	life. D		ie retired, irna]	ist		(First, Middle,		Paper		
1 and 2 should the Health and Ment em 27 is marked ther traumatice	2	James  19a. Informant's Name/Relationship  Corinne Cresson		resson 19b.				nd Numbe		M I Route Numbe		Mulhol m, State, Zip		
rtmer rtent		20a. Method of Disposition  1 Burial 2 🖾 Cremation 3 [ 4 Donation 5 Other (Speci	Removal from State	20b. Place of I cemetery Kent (	Dispos <i>r, crem</i> Cre	mation (Name natory or of matic	ne of ther place n Se	9)	3/15/	/06	Smyrr	n - City or To		
permi Depa Impo eny is		23a. Part1. Enter the tisease, or con shock, or heart failure. List only	61	d the death. Do no		3111	Mour	tain	Roac	allings i Pasade or respiratory ar	ena MD		Approximate Interval Betwoonset and D	reen
	dical Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. — Due to (or a	s a consequence of	i).		~~ <del>`</del>	un	2-0					
the death certifica by the attending ph ached for use es th	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No		e of pregnancy 2 □ Fetal death at time of death		Ectopic pro						Date of delive Month	*	'ear
requires been sign hould be	Completed by PI	Part II. Other significant conditions	contributing to death	but not resulting in	the un	derlying ca	ause give	en in Part I.		1 1 1	an 24	3 ☐ Prob	ably 4 U  psy findings a  ppletion of ca	Inknown
or Attending Physician: Titler death. Director; Atler this certificat in by the funeral director, px	Certification: To Be Co	25. Was case referred to medical examiner?  XXYes 2 No  27. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 6 Could not a determined	28a. Date of In (1 onth, 3 1 3 2 28e. Place of Ir		ime of	М 2	Bc. Injury Work 1 🔲 `	at	rsing Ho	The 5 Residence	dence MX	Other (Specificurred	recido	4
To the Hospital	Medical	29a. Certifier (Check only one)  29b. Signature and title of certifier	hysician: To the bes miner: On the basis and manner s	of examination and	death Vor inv	estigation,	in my of	e, date an pinion, dea number	d place, a	ed at the time,	cause(s) and date and place 29d. Date sig	e, and due to	the cause(s)	z f.H
Sta Registra		30. Name and address of person who T. A. Low Low 31. Date filed (Month, Day, Year)  MAR 1 5 20	wo, m	death (Item 23a) (1		111	Per	OCME in St	reet		March i			01_

			For State Registrar	State of I	Maryland / Dep	ertificate of D		ntal Hygier	2006 1	17848
		A	Decedent's Name (First, Middle	, Last)				Date of Death		3. Time of Death
	Physici	an	Joanne				n		7th 2000	1345 M
	/Medic		4a. Facility Name (If not institution		er)	4b. City, Town, or L			4c. County of Death	
	Examin	ier	Johns Holki	0		BILL	imore		N/A	
1 to 1			5. Social Security Number		Age (In yrs. last birthda)			Date of Birth	9. Birtho	lace (State or Foreign
	Funeral Director		232-56-7181	1 ☐ M 2 🂢 F	71 Yrs.	Months Days	Hours Min.	(Month, Day, Ye)		Virginia
			Usual Residence of Decedent		/ 4			10 to 1 p - 1		
	ylan		10a. State 10b. County		10c. City, Town or I	Location			1	Od. Inside City Limits
	9 Ma	cto	Maryland Balt	imore	Dunda	alk				1 ☐ Yes 2 🔀 No
	11 the	Director	10e. Street and Number			10f. Zip Code		10g.	Citizen of What Cour	ntry?
	15 wi		1910 Ewald Aven	ue		21222		I	Inited Sta	
	dea	Funeral	11. Marital Status	12. Was Decede Armed Force	ent Ever in U.S. 13	. Was Decedent of His If Yes, specify Cuban,	panic Origin? (Speci Mexican, Puerto Ric	fy Yes or No- can, etc.)	14. Race - Americ Black, White,	
9	or Hr		1 Never Married 2 Marri		<b>X</b> No		Specify:		Specify: Whi	te
21215-0036	s within 72 hours after death with the Maryland liene. Than "natural", or items 23s or 28e-1 show The Marical Examination must be inclifted at	d by	3X Widowed 4 □ Divorced	Year or Date						
ν.	nation of the	Completed	15. Decedent (Specify only highes	's Education it grade completed)	(Giv	edent's Usual Occupat re kind of work done du DO NOT use retired)	on ring most of working		. Kind of Business/In	dustry
12	within ene. than	dm	Elementary/Secondary (0-12)	College (1-4	or 5+)					
2	il Hygiene. Other thai		7 years 17. Father's Name (First, Middle,	( ast)		Housewife	8. Mother's Name (I	First, Middle, Maid	Own Home	
and	ed la be	Be				'				
2	should by	ပ္	John Breeden  19a. Informant's Name/Relationsl	nin (Tyne Print)	19h Mai	ling Address (Street an	Lacie		Vault tv or Town State Zin	Code)
Maryland	″ ™ œ ⊒									
dî.	feal feal m2 her		Terry Collins 20a. Method of Disposition	(Son	20b. Place of Disc	O Wareham F position (Name of	Dat		ryland 21  Location - City or To	
وّ	in it of l		1 Burial 2 Cremation	3 Removal from St	ate	ematory or other place,	1	2006		7
Baltimore,	permit. Pages 1 Department of H Importent: if ite any njury or ot once.		4 Donation 5 Other (S)			Serv. Corp		2006 1	lowson, Ma	ryland
Bai	Dep Impo		21. Signature of Funeral Service	· Man	DOIK I	Duda-Ruck F	uneral Ho	me of Du	ındalk, In	c.
	40240		23a. Part . Enter the disease, or	U/KUS	yeard the treath Do not o	7922 Wise 7	venue Du	ndalk, M	laryland 2	1222 Approximate
1			shock, or heart failure. List	only one cause on eac	n line.			ospiratory arrest,		Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	_a. Co	ngestilve	heast )	Tailuse			
	/Medical Examiner		rosuming in dodary	Due to (or	rasa consequence of):					10.7
	a Spar	er	Sequentially list conditions,	b. Due to (or	ras a consequence of):	tem Dis	cuse			1498613
	ed isit	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	8	as a consequence on.					
_	and and Il-trar	Examin	that initiated events resulting in death) Last	c. Due to (or	r as a consequence of):					
760,	te be executed ysician and ie burial-transit	calE								
687	ā × ā			d.						of 975000 -541
×	leath certificat attending phy if for use as the	Physician/Med	IF FEMALE:	23c. If yes, outco	ome of pregnancy				23d. Date of deliv	erv
Вох	atten for u	cian	23b. Was decedent pregnant in the past 12 months?			B Ectopic pregnancy Control of the c			Month	Day Year
P.O.	the dr the ched	ysic	1 ☐ Yes 2 █Mo 9 ☐ Unknown	9□ Unknow						
	Physician: The law requires that the death certifica this certificate has been signed by the attending phiral director, page 2 should be detached for use as the		Part II. Other significant condition	ons contributing to dea	th but not resulting in the	underlying cause giver	in Part I.	23e. Did tobac	co use contribute to t	he cause of death?
ds	uires sign ld be	d by						1 🗆 Yes	2 □ No 3 □ Pro	oably 4 <b>E</b> Unknown
Records,	w requir been si should	Completed						24a. Was an	24b. Were auto	opsy findings available
Rec	has ge 2	E						autopsy performed	prior to co death?	impletion of cause of
a	ician: Th certificate rector, pag		25. Was case referred to medical				CO Diseased Death	1 Yes 2	(No 1 ☐ Yes	2 No
Vital	sicia certi recto	Be C	examiner?	Hospital	patient 2 ER/Outpati	Othor	26. Place of Death (		e 6 ☐ Other (Speci	6.1
Division of	Phys r this ral di	7	1 Yes 2 No 27. Manner of Death	28a. Date of (Month)		IBIIL 3 DOA	4   Nursing Home	d. Describe how		(y)
on	ding h. h. After funer	tion	1 Natural 5 Pendin 2 Accident investi		Day Year) Injury		es 2 No			
S	Attending or death. sctor: After by the fune	fica	3 ☐ Suicide 6 ☐ Could	not be 28e. Place of	of Injury - At home, farm,	street, factory, office	28		t and Number or Rur	al Route Number,
Θ	after Dirs	Certification:	4 Homicide	building	g, etc. (Specify)			City or Town, S	itate)	
	spite nours nerei				pest of my knowledge, de					
	s Ho 24 h s Fu letely	Medicai	(Check only 2 Medical one)	Examiner: On the bas and manne	sis of examination and/or or stated.	investigation, in my opi	nion, death occurred	d at the time, date	and place, and due t	n the cause(s)
	To the Hospitei or Attending Physician: The within 24 hours after death.  To the Funerei Director: After this certificate his completely filled in by the funeral director, page	Me	29b. Signature and title of certifie	r		29c. License			Date signed (Month,	
			188 march	nus - Phy	sician	Do	005480	M	arch 7th	2006
.5	-		30. Name and address of person	who completed cause	of death (Item 23a) (Typ	e, Print)				
10	) [		Eric E. Hr	well in	D. 4940		AVE BI.	timore,	and D	
	St	ate	31. Date filed (Month, Day, Year)	32. R	pistrar's Signature					
10° m	Regist	rar	MAR 1	5 2006	Lagran St.	carelle				

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** March 14, Da 2006 Year 0240 Barbara Cupp /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Bel Air Harford Upper Chesapeake Medical Center | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | June 29. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2√2 F 219-36-6246 June Maryland Director Usuat Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ehow traumatic event, the Madical Example: must be notified at Bel Air Harford Md. 1 ☐ Yes 2 No Director 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 21015 305 Mauser Drive U.S.A. 'natural', or itema 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ XNo If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 🔀 Married white 1 ☐ Yes 2 XNo Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) religous education 12 should be filed w h and Mental Hygier 7 is marked other th teacher 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mary Ann Harrison Roman James Steiner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If Item 27 is any injury or other tra 305 Mauser Drive, Bel Air, Md. 21015 John Gary Cupp/husband 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Bayview Crematory Baltimore, Md. 4 □ Donation 5 □ Other (Specify) 3/20/06 21. Signature of Funeral Service Licensee Schimunek Funeral Home of Bel Air, Inc. 610 W. MacPhail Road, Bel Air, Md. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) /Medical Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Examine use as the burial-transit Due to (or as a consequence of): the attending physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent preg 3 Ectopic pregnancy in the past 12 m. Month Day Year 4☐Pregnant at time of death 5 Other (specify) Ö 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 1 Yes 2 1 No 2 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA ို 1 ☐ Yes 2 ☐ No 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: Hospital or Attending 1 Natural 5 Pending death. 2 Accident investigation Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours after To the Funeral Direct 4 🗌 Homicide 1 Pertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Dav. Year) 29c. License number (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene () () For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Year James Russell Coolev 7:56 AM M March 13, 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Gilchrist Center for Hospice Care Towson Baltimore 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex Date of Birth (Month, Day, Year) 07/13/1952 Birthplace (State or Foreign Country)
 CT **Funeral** 12M 20F 53 045-46-6147 Director Usual Residence of Decedent with the Maryland 10a State 10b. County 10c. City, Town or Location of 2 should be filed within 72 hours after death with the Marylan th and Mental Hygiane.
27 is marked other then "natural", or itema 23a or 28a-f show traumatic event, the Medical Examinant must be a voited at 10d. Inside City Limits Director MD Baltimore 1 ☐ Yes 2 🚉 No Reisterstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1 Johnsborough Ct. 21136 United States Funera 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: White Be Completed by Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Defense Contractor Elementary/Secondary (0-12) College (1-4or 5+) Electrical Engineer 5+ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be life Department of Heelth and Mental Hy Important: if Item 27 is marked oth any liury or other traumatic event 2008. James Love Cooley Anita Gore 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tammy Baran/Wife 1 Johnsborough Ct. Reisterstown, MD 21136 20b. Place of Disposition (Name of cemetery, crematory or other place) Date Mar 15 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Beltsville, Maryland Chesapeake Crematory 4 ☐ Donation 5 ☐ Other (Specify) 2006 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
Cremation and Funeral Alternatives 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 8717 Green Pastures Drive Baltimore, Maryland Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Melanoma Physician jears /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, any, loading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to for as a consequence or Examiner the death certificate be executed the attanding physiclen and resulting in death) Last Due to (or as a consequence of) 68760, Certification; To Be Completed by Physician/Medical Box IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) Ö 9 Unknown 9 Unknown signed by α. The law requires thet Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 4 / Unknown 1 Yes 2 No 3 Probably 24a. Was an autopsy performed?
1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate of Vital erei Director: After this certific filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death | Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) NDSPCC 1 ☐ Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of D. ath 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Division 5 Pending investigation Injury death. 1 Yes 2 No 2 ☐ Accident 3 ☐ Suicide 6 Could not be determined Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) or A 4 Homicide To the Hospital within 24 hours e To the Funerel I completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of cartifier 29c. License number 29d. Date signed (Month, Day, Year) March 13 2006 D 58203 uns 30. Name and addr iss of person who completed cause of death (Item 23a) (Type, Print) Charles St Bostonie up 21204 Charles ms AMON 6601 N, 31. Date-filed (Month, Day, Year) 32. Registrar's Signature State 5 2006 Boseles Registrar

DHMH 17 Rev 1/2001

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Amend item#30, perDVR, 1853, 3/15/06 TT

Amend item#30, perDVR, 1853, 3/15/06 TT

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** William Ρ Church March 10 2006 6: 30 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 4725 Mawani Rd. Baltimore County Baltimore If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months XXM 2DF Yrs 235 24 0251 Director Julv 1 1922 Hundred, West Va. Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r then "naturel", or iteme 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Baltimore Maryland Baltimore County Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4725 Mawani Rd. 21206 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status filed within 72 hours efter 1 XYes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: þ Specify 3 X Widowed 4 ☐ Divorced W II White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 7 is marked other then traumatic event, the Mi Welder Martin Co. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be Department of Heelth and Mental Important: If I am 27 is marked 4 any light yo rother traumatic even page. Paul W Church Jr. Jessie Hughes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4725 Mawani Road Paul W Church Baltimore, Maryland 21206 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State ₩ Burial 2 Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) Moreland Memorial Park Cent. March 15 2006 Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 7401 Belair Rd. Lassahn Funeral Home Baltimore, Md. 21236 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between nset and Death Immediate Cause (Final disease or condition resulting in death) Congestive **Physician** 612) /Medical Examiner Adherosde iodic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner To the Hospitel or Attending Physician: The law requires that the death certificate be executed ettending physicien and for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 4☐Pregnant at time of death 5 Other (specify) certificate has been signed by the rector, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 2 🖪 No 1 Yes 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No performed2 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? director Be 26. Place of Death Check only one Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ۵ this 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification; After 5 Pending death. 1 Tes 2 No Director: / 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after d To the Funeral Direct completely filled in by 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medicai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 3/10/06 38048. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Steven Charles Blasdell Baltimore, MD 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Joseph MAR 1 5 2006 Registrar

DHMH 17 Rev 1/2001

1. CHARCE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend item#1,26,per/M, (853,3/15/06 IT State of Maryland / Department of Health and Mental Hygiene) Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Daisy Chapman Month 3 Day 2006 6 10:30a M 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death NA 3101 Cliftmont Ave. Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 10 M 2XF Months Yrs. 8-24-18 N.C. 87 244-42-0134
Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 X Yes 2 ☐ No Baltimore NA Md. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21218 1329 Gorsuch Ave. USA 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: Black 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Other Peoples Homes Domestic 9th grade 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Townes Lewis Willie Mae Robert 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1329 Gursuch Ave., Baltimore, Md. Husband Albert Charman 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 3-10-06 Baltimore, Md. Woodlawn Cem. 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Baltimore, Md. 21202 1101 E. North Ave. March F.H. East 23a. Part1. Enter the disease, or complications that caused the death. Both enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) BRAIN TUNCR Due to (or as a consequence of): Emver Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Month Year Day 4 Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Z No 1 ☐ Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Cther: 4 Nursing Home Sensidence 6 Nother (Specify) 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 27. Manner of Death

**Physician** /Medical Examiner The law requires that the death certificate be executed ed by the attending physicien and detached for use as the burial-transit Division of Vital Records, P.O. Box 68760. certificate has been signed by rector, page 2 should be detac or Attending Physician: neral Director: After this certific tilled in by the funeral director, death. within 24 hours after d

To the Funeral Direct

**Physician** 

/Medical

Examiner

Director

Funeral

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Completed

Be

**Funeral** 

Director

with the Maryland

permit. Pages 1 and 2 should be tiled within 72 hours atter death with the Marylan Department of Health and Mentat Hygiene. Important: If item 27 is marked other than "natural; or items 23a or 28a-f show any injury or other traumatic event, the Mudical Example intuitive notified at once.

Baltimore, Maryland 21215-0036

Examiner Physician/Medical Completed by Be ို Certification:

IF FEMALE 23b. Was decedent pregnant

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Yes 2 No

29b. Signature and title of certifier

Natural

2 Accident

3 ☐ Suicide

29a, Certifier

4 | Homicide

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

m.D

29d. Date signed (Month, Day, Year)

066

31. Date filed (Month, Day, Year)

5 2006

5 Pending

investigation

determined

6 Could not be



28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

DHMH 17 Rev 1/2001

State

Registrar

State of Maryland / Department of State of Maryland / Department of Certificate	
Decedent's Name (First, Middle, Last)	2. Date of Death 3. Time of Death
Physician EVA F. DAVIS	Month Day Year 3:00 PM
Examiner 4a. Facility Name (If not institution, give street and number) 4b. City, Total	wn, or Location of Death 4c. County of Death
Will took to	Ulmone city N/A
	Days Hours Min. (Month, Day, Year) Country)
Director  Usual Residence of Decedent	SEPT. 8, 1933 VIRGINIA
100 City Tourney	10d. Inside City Limits
10a. State 10b. County 10c. City, Town or Location	7LTIMORE CITY 1XYes 2 No
10a. State 10b. County 10c. City, Town or Location  WARIJLAND N/A 10f. Zip Co	
5707 NORWOOD AVENUE	21207 USA.
The stylest and Number  10e. Stylest and Number  10e. Stylest and Number  10e. Stylest and Number  10e. Stylest and Number  10e. Stylest and Number  10e. Stylest and Number  10e. Stylest and Number  10e. Stylest and Number  10e. Stylest and Number  10e. Stylest and Number  11e. Was Decedent Ever in U.S. Armed Forces? 11e. Was Decedent If Yes, specify 11e. Stylest and Number  11e. Stylest and Number  11e. Stylest and Number  11e. Was Decedent If Yes, specify 11e. Stylest and Number  11e. Styl	nt of Hispanic Origin? (Specify Yes or No-
3 Widowed 4 Divorced Year or Dates:	BLACK
	done during most of working
Elementary/Secondary (0-12) 2 College (1-4or 5+) CLAIMS	
	18. Mother's Name (First, Middle, Maiden Surname)
The part of the pa	RUTH HARRISON
The property of the property o	Street and Number or Rural Route Number, City or Town, State, Zip Code)
20b. Place of Disposition (Name cametery, crematory or othe	CWOODAVE, BALTTHINE HD, 21207  Of Date 20c. Locatin - City or Town, State
	EME. 03-16-06 ELKRIDGE, HARYLAND
E ETTE. Ot Cinneture of Euperal Continue Linguistics	Address of Facility BROWN JR, FUNERAL HOME
ietuch N. William 2, 37	5 N FULTON AVE. BALTO, MO. 21217
23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode o shock, or heart failure. List only one cause on each line.	of dying, such as cardiac or respiratory arrest,  Approximate Interval Between
Physician Immediate Cause (Final disease or condition	Onset and Death
/Medical resulting in death)  Due to (or as a consequence of):	6009
Sequentially list conditions.	
fi any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):	
Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):	
d d d d d d d d d d d d d d d d d d d	
IF FEMALE: 23c. If yes, outcome of pregnancy 1	23d. Date of delivery
IF FEMALE: 23b. Was decedent pregnant in the past 12 mgnths? 1	
9 Unknown 9 Unknown	
is specified by coronary artery disease	1 ♥Yes 2 No 3 Probably 4 Unknown
The law requirements the law r	24a. Was an autopsy 24b. Were autopsy findings available prior to completion of cause of
COM COM COM COM COM COM COM COM COM COM	performed death?  1 Yes 2 No 1 Yes 2 No
25. Was case referred to medical examiner?  1   Yes 2   No	26. Place of Death (Check only one)
1 Yes 2 No Hospital: 1 Impatient 2 ER/Outpatient 3 DOA 28a. Date of Injury 28b. Time of 28c.	Other: 4 Nursing Home 5 Residence 6 Other (Specify)  Injury at 28d. Describe how injury occurred
28c. Date of Injury 28c. Injury 28c. Time of 28c. Date of Injury 2	. Injury at 28d. Describe how injury occurred Work? 1 □ Yes 2 □ No
1 Matural 5 Pending (Month, Day Year) Injury  1 Matural 2 Accident 3 Suicide 4 Homicide	office 28f. Location (Street and Number or Rural Route Number,
28a. Date of Injury (Month, Day Year)  27. Manner of Death  1	City or Town, State)
29a. Certifier 1 Certifying Physicien: To the best of my knowledge, death occurred at to (Check only 2) Medical Exeminer: On the basis of examination and/or investigation. in	the time, date and place, and due to the cause(s) and manner as stated.
one) and manner stated.	my opinion, death occurred at the time, date and place, and due to the cause(s)
29c. L	License number 29d. Date signed (Month, Day, Year)
12 Y San Hutzey	RES-000 MARCH & 2006
30. Name and address of person who completed cause of death (Item 231) (Type, Print)  SAMNEL P. ANDORSWY 51	NM HOSPITAL OF BATTIMORE
State 31. Date filed (Month, Day, Year) 32. Registrar's Signature	MAIL HOSPILAL OF CHUINNING
Registrar MAR 1 5 2006 Mague & Appell 8	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** March 1015 DORSEI Doroth 2006 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore 5. Social Security Number 6. Sec Medical Center 1 Yea. 8. Date of Birth (Month, Day If Under Year II Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex Age (In yrs. last blirthday) **Funeral** Hours Months 1 M 2 F 214-20-6508 Yrs Director LAND Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits th and Mental Hygiene. I? Is marked other than "natural", or items 23a or 28a-f show traumatic event, the Madical Examinar must be rectified at 1 XYes 2 No Director MARYLAND 10f. Zip Code 10g Citizen of What Country? 10e. Street and Number 40u Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status Pages 1 and 2 should be filed within 72 hours after ☐Yes 2 No f Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) BORE OTHGRADE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Po TWOOL OUISE 2 (UNKNOWN) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Department of Health a Important: If Item 27 is any injury or other trains 000. 2113 CALLOWAVE. (DAUGHTER ALTO. ML A KOBINSON 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) METRO CREMATORY 03-17--06XDAL 22. Name and Address of Facility BRO TR. FUNERAL 21. Signature of Funeral Service Licensee BALTO, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Sepsis

Due to for as a consequence of) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter the ordering Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) attending physician a for use as the burial-Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Day 4 Pregnant at time of death 5 Other (specify) the 9 Unknown 9 Unknown cete has been signed by page 2 should be detact 23e. Did tobacco use contribute to the cause of death? Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy certificete 20 No no 24 hours after death.

The Funeral Director: After this certificate the Funeral director. After this certificate the Funeral director, pr 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner Other: Hospital: 2 No 1 Inpatient 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 1 Tes 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 Natural 1 Yes 2 No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place ol Injury - At home, farm, street, factory, office building, etc. (Specify) 28I. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier ٥ March 12, 2006 31 YUM - XU, M.D AV4176435X16713

State Registrar

Caralle 8

Greene

Bultimore.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

5 2006

UMMC

32. Registrar's Signature

Rong

MAR 1

31. Date filed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene 0 0 6

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				Ce	ertificate o	f Death	Re	g. No.			
		1. Decedent's Name (First, Middle, La	est)				2. Date of Deet Month	h Dav	Year	3. Time of	Death
	sician	Gertrude N	J Dickerso	11)			3	10	2006	6:00	) PM
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Fune	ral	,		yrs. lest birthday	Months De			Yeer)	9. Birthpla	ace (State o	r Foreign
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ъ.		Usuel Residence of Decedent	140	01					140	d Incido Ci	its I imple
aryler who		10a. Stete 10b. County	100	c. City, Town or L	ocation				10	ld. Inside Cil 1 🛱 Yes	
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ep L	E e	11. Maritel Status	12. Was Decedent Ever Armed Forces?	in U,S. 13	. Was Decedent of If Yes, specify C	of Hispenic Origin? ( uban, Mexican, Pue	Specify Yes or No- erto Rican, etc.)		e - America ck, White, e	tc.	
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		19a. Informant's Name/Relationship					renue, Ba		MD 2:		
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permit. Peges 'Depertment of H Important: If its any Injury or of		20e. Method of Disposition  XOXBurial 2 Cremetion 3 [	☐Removal from State	cemetery, cri	emetory or other p	olece)					
Pe Henry	ì	4 □ Donation 5 □ Other (Speci		CrestLa	wn Ceme	etery	3/17/06	Marri	otts	ville	∍,ML
vermit. Peges 1 er Depertment of Hea mportant: If Item:	ej ,	21. Signeture of Eurieral Service Lice	MSee ///	- 1	22. Name and Ad	dress of Facility W	ylie F/	H PA o	t Ba	Ito.	Go.
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		25a Part Enter the disease, or con shock, or heart failure. List only	inplications that caused the	death. Do not e	nter the mode of o	tying, such as cardi	ac or respiratory arre	est,		Approximate Interval Bet	e ween
Physicia	an									Onset and I	Death
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clan: The entificete ector, peg	0	25. Was case referred to medical				26. Place of D	eath (Check only on	e)			
Physician: The lew requires the this certificate has been signed that director, page 2 should be or	0	examiner?	Hospital:	2 ER/Outpatio	ent 3[] DOA	Other: 4 Nursing	Home 5 ☐ Reside	nce 6 Oth	er (Specify	)	
Ph.	Ξ	27. Menner of Death	28a. Date of Injury (Month, Day Yea	28b. Time	of 28c. Ir	njury et Vork?	28d. Describe ho	w injury occur	red		
I or Attending I of Attending I of Original Director: After din by the fune	atio	1 Natural 5 Pending 2 Accident investigation		ar) Injury		☐Yes 2☐No					
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Ho Ho Fu	edicai	(Check only 2 Medical Exa- one)	miner: On the basis of examend manner steted.	mination end/or i	nvestigation, in m	y opinion, deeth oc	curred et the time, da	ate and place,	and due to	tne cause(s	3)
omp vithir	ž	29b. Signature end title of certifier		_		ense number		9d. Date signe		-	
		I CO - K	SIRAG.M.	D	D	43462	1,0	ARCH	14,2	006	
	2	30. Neme end address of person who	completed cause of death	(Item 23e) (Type	Print) Ic - C	RAO. M	· D ·				
	7	5400 010 C04	RT READ \$	#108	RANDE	CLSTO	UN TIE	211	33		
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**ORIGINAL** 

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 515 AM , cken taken 2006 Mary /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Dundalk
Under 1 Year If Under 24 Hrs. 8. Date of Birth
Online Days Hours Min. Dec. 20,1929 Baltimore 7044 Belclare Road 5. Social Security Number If Under 1 9. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Months 1 ☐ M 257 F VA 76 Vre Director 527-32-4036 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show other treumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director Dundalk MD Baltimore 10e. Street and Number 10f. Zio Code 10g, Citizen of What Country? ō 'naturel', or items 23a U.S.A. death 1 Funeral 7044 Belclare Road 12. Was Decedent Ever in U.S.
Armed Forces?
1 ☐ Yes 2 ☐ No
If Yes, Give
Year or Dates: 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 Yes 2 No Specify: White þ 3X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed withir Department of Health and Mental Hygiene. Importent: If item 27 is marked other than any injury or other treumatic event. If a Me Elementary/Secondary (0-12) College (1-4or 5+) Bethlehem Steel Inspector 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Glenard C. Hamblin Maggie Stanley Stevens 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 170 Center St., Lucille Hall Cecilton, MD 21913 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ဩBurial 2 □ Cremation 3 □ Removal from State
4 □ Donation 5 □ Other (Specify) 3/14/06 Middle River, MD Holly Hill Cem. 22. Name and Address of Facility Bradley-Ashton Funeral Home, 21. Signature of Funeral Service Licensee P.A., 2134 Willow Spring Rd, 21222 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death nmediate Cause (Final Physician BAC 21 disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine use as the burial-transit requires that the death certificate be executed and Due to (or as a consequence of): Box 68760. the attending physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 DEctonic pregnancy in the past 12 months? Month Dav Year 4□Pregnant at time of death 5 Other (specify) P.O. I 1 Yes 2 No 9 Unknown 9 🗆 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an this certificate has 1 Yes 2 300 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 | Inpatient Other: 4 Nursing Home 1 ☐ Yes 2 No 2 2 ER/Outpatient 3 DOA 5 Residence 6 □Other (Specify) 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? \To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification; Injury 1 Matural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 🗀 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 1035,11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Du 2112 Switt B 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

MAR 1 5 2006

20b. Place of Disposition (Name of cemetery, crematory or other place)

Bayview Crematory 3/9/06

permit. Pages 1 and 2.
Depertment of Health an, important: If Item 27 Is m any Injury or other. Baltimore. **Physician** 

2 should be finance and Mental H

/Medical Examiner

Box 68760

P.O.

Division of Vital

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence Examiner ed by the attending physician and detached for use as the burial-transit certificate be executed Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown s been signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 HYPOTENSION, INTRAUTERINE GROWTH RETARDATION GRAM POSITIVE BACTEREMIA RESPIRATORY DISTRESS this certificate has SYNDROME funeral director, 25. Was case referred to medical examiner? 1 Impatient 1 Yes 2 No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death Certification: 28b. Time of 28c. Injury at Work? After 1 Natural 5 Pending death. hospital or Attendi 24 hours after death. Funeral Director: A stely filled in by the fu 1 Tes 2 No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital owithin 24 hours a To the Funeral Completely filled in 29a, Certifie Medical (Check only one)

30. Name and address of person who completed cause of death (ftem 23a) (Type, Print)

Santiago

/ Mother

19a. Informant's Name/Relationship (Type, Print)

1 ☐ Burial 2 Cremation 3 ☐ Removal from State

Michele Doerfler

4 ☐ Donation 5 ☐ Other (Specify)

20a. Method of Disposition

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21. Signature of Funeral Service Licensee Rayer or town kind Funeral Home P.A. 1201 Dundalk Ave. Baltimore, Md. 21222 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Finaf disease or condition resulting in death) TYTZAVENTRICULAR AND SUBARACANOID HEMORPHAGE 34 HOURS Due to (or as a consequence of) PREMATURITY 23d. Date of delivery Month Day Year 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 2 No 1 Yes 1 ☐ Yes 2 € No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29 medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Dev. Year) D0047 998

Michele Doerfler

20c. Location - City or Town, State

Baltimore, Md.

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

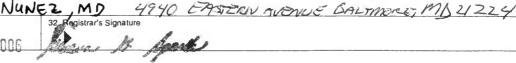
105 S. Conkling Street Balto. , Md.

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year) 5

Jeanne



			For	State of Marylar	•			lental Hygie	ne	
			1 - State Ragistrar		Ce	rtificate of	Death	Reg.	No. U U 6	0/858
	Physici		1. Decedent's Name (First, Middle, La BERNAD I A	1- 0	711.	FATO		2. Date of Death Month	Day Year	3. Time of Death
5	/Medic Examin		4a. Facility Name (If not institution, give			4b. City, Town, o	r Location of Death	Marca	4c. County of Deat	7 .
			Sinai Hospi	tal of Balt	More	Bulti	MORE		1	IA
	Funeral Director		5. Social Security Number 6. 8	Sex 7. Age (In yrs.	last birthday)	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye APRIL 25		hplace (State or Foreign untry)  ARV LAND
	D		Usual Residence of Decedent		-			TIPRILAS	12111	1
	farylar obow	ō	10a. State 10b. County	10c. Cit	ty, Town or Lo		1 -111	ar M	1711	10d. Inside City Limits 1 ☑Yes 2 ☐ No
	r 28a-1	Directo	10e. Street and Number	I A		10f. Zip Code	LTIMO		Citizen of What Co	1
	th with	alD	3510 JO	ANN DRIV	E		2124	14	US	A.
	er dee items	Funeral	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	.S. 13.	Was Decedent of H If Yes, specify Cuba	lispanic Origin? (Spe an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White	
036	urs aft	by	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 💆 Divorced	1 ☐ Yes 2 ☑No If Yes, Give Year or Dates:		1☐ Yes 2🗖 No	Specify:		Specify: B	I ACK
5-003	within 72 hours after deeth with the Maryland ane. then 'naturel', or items 23a or 28a-f ehow the Masical Examiner must be notified at	Completed	15. Decedent's E (Specify only highest gr	ducation ade completed)	(Give	dent's Usual Occup	during most of worki	ng 16	b. Kind of Business/	Industry
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	il Hygid other	Be Co	17. Father's Name (First, Middle, Last	)	LLMIII	1201,1-11		(First, Middle, Mai		.0212201120
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	s 1 and f Health item 27 other to		ANDREA MEANS STEPHE 20a. Method of Disposition	20b. F	Place of Dispo	SKIDGL psition (Name of matory or other place	/! t	BALTIM Date 200	c. Location - City or	0,21230 Town, State
altimore,	Pages nent of int: If its ury or o		1 ☐ Burial 2 ☑Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci	Hemoval from State			R1/03-1	13-06 /	BALTIHON	RE MARVIANO
3alt	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "naturel", or Items 23a or 28a-1 show any lojury or other traumatic event, the Medical Examinal must be notified at angel once.		21. Signature of Funeral Service Lice	nsee / / ) 1 M. i.		2. Name and Addre	ss Facility 13 F	MIN TR	FUNER	PAL HOME
	405 4 Q	-	23a. Part1. Enter the disease, or con	colications that caused the deat	th. Do not en	2 140 N ter the mode of dvin	, I-ULTON	AVE, L	BALTO, F	10.21217 Approximate
	Physician	0 4	shock, or heart failure. List only Immediate Cause (Final	one cause on each line.	1 .	1 .			0	Interval Between Onset and Death
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	Examiner	_	Sequentially list conditions,	b. Les l'va	yor i	Faili	we			3 days
	uted d ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Sep sis	delice oi). »					3 days
oʻ	be executed siclen and burial-transit		resulting in death) Last	Due to (or as a conseq		1 (	11 -			2 /
8760,	the the	dical	•	d. Tutest	4 nal	her to	ra tron			3 days
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<u>.</u>	death	siclai	in the past 12 months? 1 □ Yes 2 IX No	1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d 9 ☐ Unknown		∃Ectopic pregnancy ∃ Other (specify)	·		Month	Day Year
P.O.	d by the	Phys	9 Unknown  Part II. Other significant conditions		ulting in the u	underhing course au	on in Dart I	23a Did tohac	no uso contributo to	the cause of death?
ds,	signe	d by	Fattii. Ottor significant conditions	contributing to death but not les	alting in the t	indenying cause giv	en in carti.		<b>\</b>	obably 4 Unknown
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- B	The lavele has page 2	Com						autopsy performed	d? death?	1
Vita Vita	icien: Th certificete rector, pag	Be	25. Was case referred to medical examiner?	Hospital:		oth Oth	26. Place of Death			
ŏ	a Phys er this eral di	n: To	1 Yes 2 No  27. Manner of Death	28a. Date of Injury	ER/Outpatie	III 3LI DOA	4   Nursing no	ne 5 ☐ Residenc 28d. Describe how	e 6 □Other (Specinjury occurred	cify)
ion	ending I sath. or: After he funer	atlo	1 Natural 5 Pending 2 Accident investigation		Injury		Yes 2 □No			
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_	To the Hospitel or Attending Physicien: The within 24 hours eithe dash.  To the Funeral Director: After this certificete his completely filled in by the funeral director, page		29a. Certifying P	nysician: To the best of my kno	owledge, deat	th occurred at the tin	ne, date and place,	and due to the caus	e(s) and manner as	stated.
	the Ho	ledical	(Check only 2 Medical Exa	miner: On the basis of examina and manner stated.	ition and/or in	ivestigation, in my o	pinion, death occurr	ed at the time, date	and place, and due	to the cause(s)
	To To com	N	29b. Signature and title of certifier	0 01		29c. Licens			Date signed (Montl	
	127		30. Name and dress of person who	completed cause of deat filter	n 23a) (Tvoe	Print)	06549	2	1/4/200	00
	7		/ Vashua	Rheinbolt		. 1 (	pital	of Ba	Himore	
	Sta Registr		31. Date filed (M nth, Day, Year)	32. Registrar's Signa	ature	inai tos	1	<b>3</b> 0/	000	
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RJD		1 - State RegistrarAm	end #10f&	19b Per In	nf G8	65 Ce	rtifica	te of	Death			Reg. No	. U U	U	31000	
Phy	sician	1. Decedent's Nam	ne (First, Middle, Las	st)							2. Date of D Month	eath Da	v '	rear	3. Time of Death	
	edical	James Otho					Ewell March 2,					2, 2	006		1030 A. <sup>™</sup>	
Exa	miner	4a. Facility Name (If not institution, give street and number)					4b. City, Town, or Location of Death						4c. County of Death			
		320 Burnside Court  5. Social Security Number 6. Sex 7. Age				Joppa  (In yrs. last birthday) If Under 1 Year If Un			If Under	24 Hrs		Harford				
Fune Direc		218-34-				onths Days Hours Min.			8. Date of B (Month, D	9. Birthplace (State or Foreign Country) MD						
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rylan	1	10a. State 10b. County 10c. City, Town or Location											1	0d. Inside City Limits		
ith the Marylan	Ş	MD	MD Joppa										1 ☐ Yes 2 No			
or 28	Director	10e. Street and Number				10f. Zip Code			2	8 <b>21085</b>				Citizen of What Country?		
ath w	la la	320 Burnside Ct.														
Maryland 21215-0036 d 2 should be filed within 72 hours after death with the Maryland th and Mental hygiene. 77 ie marked other then "naturel", or lieme 23a or 28a-f ehow	by Funeral		11. Marital Status  1 Never Married 2 Married  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Decede Armed Force  14 Yes, Give Year or Date				Was Decedent of Hispanic Origin? (Specify Yes or If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:				cify Yes or N Rican, etc.)					
5-0 72 ho	ted	15. Decedent's Education 16a. Deced (Specify only highest grade completed) (Give						dent's Usual Occupation 16b					. Kind of Business/Industry			
2 ig ig i	Completed	Elementary/Secondary (0-12) College (1-4or 5+)				(Give kind of work done during n life. DO NOT use retired)							altimore City ept. of Parks			
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Dan in particular in particula	Be	17. Father's Name (First, Middle, Last)						18. Mother's Name (First, Middle, Mai				e, Maider	iden Sumame)			
laryland 212- 2 should be filed within and Mental Hygiene.	ုင	James M. Ewell						Elsie Rounds					04.000			
≥ 5 € 5		19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or RudoppaumbMD ity o27108% etc., Zip Code)  Pearlie Ewell-Wife  320 Burnside CT., Pikesville, Md. 21208											21208			
Baltimore, Department of Hea Medicant: If Item		1 🗆 Burial 2	20a. Method of Disposition  1 Burial 27 Cremation 3 Removal from State 4 Donation 5 Other (Specify)  20b. Place of Disposition (Name of cemetery, crematory or other place)  Metro Crematory Inc. 3/9/06  20c. Location - City or Town, State  Baltimore, Md  22. Name and Address of Facility  March F/H West													
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		, ,	the disease or come	olications that caused	d the death								ce, I	10	21215 Approximate	
		snock, or nea	art tawure. List only	one cause on each III	ne.					oardiac of	respiratory	a1103t,			Interval Between Onset and Death	
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Box 68760, eath certificate be executed	edical Examiner	that initiated event resulting in death)	S	c.  Due to (or as												
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O 5 5	Physician/M							Ectopic pregnancy  Other (specify)					23d. Date of defivery Month Day Year			
ls, P.	<u>a</u>												co use contribute to the cause of death?			
cords	ted						10	1 Yes 2 No 3 Probably 4 Unknown								
Division of Vital Records, or Attending Physician: The law requirest after death.  Director: Attending certificate has been signed to the physician of the phys	0											24a. Was an autopsy performed?  1♥ Yes 2□ No 24b. Were autopsy findings avail prior to completion of cause death?  1♥ Yes 2□ No				
Vital F	Be	25. Was case refe examiner?		Hospital				104		e of Death	(Check only	one)				
Of Of Physical Physic	ဥ	1 Yes 2		Hospital: 1 Inpatie					Home 5 Residence 6 Nother (Spe				( scene)			
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isio	cat	2 Accident 3 Suicide	investigation 6 Could not be		M 1 Yes 2 No			28f. Location (Street and Number or Rural Route Number,								
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Divi To the Hospitel or At within 24 hours after or To the Funeral Direct	edical (	29a. Certifier  (Check only one)  29a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.													lated. the cause(s)	
To th within	Me	29b. Signature and	d title of certifier				T T							Date signed (Month, Day, Year)		
		1 fan	uch Dou	Southall MD				O.C.M.E.					ch 3, 2006			
_		30. Name and add	old F. Sim	completed cause of d	death (Item	23а) (Туре,	Print) 1	11 P	enn S	treet	, Balt	imor	re Mar	ry1a	nd 21201	
	State	31. Date filed (Mor	nth, Day, Year)	32. Registr	rar's Signat	шгө	1									
Reg	istrar	E.	MAR 1 5 20	06	as A	ure	Section 1									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** Faulkner Month 19:39 M lames 2006 March 07 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Johns HOPKINS Hospital If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sev 7. Age (In yrs. last birthday) **Funeral** Days Months Hours Min 1**X** M 2□F 215-40-3135 Yrs. Director 64 12 - 29 - 41Md Usual Residence of Decedent Pages 1 end 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. The sait: if item 27 ie marked other than "naturel", or items 23a or 28s-f ehow try or other treamait en ordinad arry or other treamaits event, its Healtesi Exercites marke motified at 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits 1 XYes 2 □ No **Funeral Director** Md. Baltimore NA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 212 13 1401 E. Oliver Street USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2X No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: Black Be Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 8th grade Pipe Layor Calvert Utilities 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) James Arthur Faulkner, Jr. 2 Evelyn Custis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mildred E. Faulkner 1015 Withspoon Rd., Baltimore, Md. Disposition (Name of 20c. Location Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Denation 5 ☐ Other (Specify) permit. Page Department of Important: if any injury or pncs. Arbutus Mem. Park 3-14-06 Arbutus, Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 21202 Baltimore, Md. March F.H. East 1101 E. North Ave. 23a. Print. Enter the disease, or complications that caused the feath. Do not enter the mode of dying, such as cardiac or respiratory arrest, ick, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death ate Cause (Final myocardial Physician infarction 3weeks dis last or condition re ulting in death) /Medical Due to (or as a consequence of): Examiner month pneumocystis carini pheumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner anding physician and use as the burial-transit The law requires that the death certificate be executed stroke ischemic resulting in death) Last Due to (or as a consequence of) Box 68760. immunodeficiency virus Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant for u 3 Ectopic pregnancy in the past 12 months? Month Day 4☐Pregnant at time of death 5 Other (specify) P.O. I ed by the detached 9 Unknown 9 ☐ Unknown page 2 should be de Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. Completed by 3 ☐ Probably 4 ☐ Unknown 1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 1 Yes 1 Tyes Hospital or Attending Physicien: funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: ix Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Yes 2 No 2 ER/Outpatient 3 DOA this. 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No death. investigation hours after deat uneral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ۵ 4 Homicide filled in 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check only one) within 2 ş 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar anse

Hansie Matheli

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2006

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32. Segistrar's Signature

Res-000

2006

March

Horking Hospital 600 NORTH WOIFE STREET BALTIMORE MD 21287

MES	GREEN	١ .	For 1_ State	State of Maryland / Dep	artment of Health and Mertificate of Death		211116	07861
			Registrar  1. Decedent's Name (First, Middle, Last)		Timcale of Death	Rag. N	fo:	3. Time of Death
	Physici	an	Tame	s Gre	en	Month D	), 2006	1815 P M
1	/Medic Examin		4a. Facility Name (If not institution, give s		4b. City, Town, or Location of Death		c. County of Death	10171
	LAdimi	C.	5808 JONQUIL AVEN	UE	BALTIMORE CITY		NIA	
	Funeral		5. Social Security Number 6. Sex 2/8-58-45/9 12	M 2□F  7. Age (In yrs. last birthday, Yrs.	If Under 1 Year   If Under 24 Hrs.   Months Days Hours Min.	8. Date of Birth Month, Day, Yea	9. Birthp Coun	place (State or Foreign
	Director	9	Usual Residence of Decedent	020		sune 26	1902 M	aryland
Po o o	Mod #		10a. State 10b. County	10c. City, Town or L	ocation		1	0d. Inside City Limits
Mon	Se-fer	Director	ma N	1A	Daltimo	re		1'XYes 2□No
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ē,	f Healt frem 2 other	1 3	20a. Method of Disposition	20b. Place of Disp			Location - City or To	
OE S	Page ent nt: If ry or		1 Burial 2 □Ĉ)emation 3 □R 4 □Donation 5 □ Other (Specify)	emovariiom state	nemorial Ch. 3-10	8-06 Sh	ady si de	maryland
Baltimore	Depermit. Depertm Importal any inju		21. Signature of Funeral Service Lizense	2	22. Name and Address of Facility	FredHILT	on tass	
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			shock, r san failure. List only on	cations that caused the death. Do not er le cause on each line.	nter the mode of dying, such as cardiac	or respiratory arrest,	Λ	Approximate Interval Between Onset and Death
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ds,	The law requires that the death certificate be executed to has been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	ρ	Part II. Other significant conditions con	Inhouting to death but not resulting in the	underlying cause given in Part I.	1 Tes	o use contribute to the	
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<b>/</b>	ysicii nis cer i direci	To B	examiner? 1. Yes 2 No	ospital: 1 Inpatient 2 ER/Outpatie		me 5 Residence	6 XOther (Specif	y) AT SCENE
0	Attending Physician: r death. actor: After this certific by the funeral director.		27. Manner of Death 1 ♣Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year) 28b. Time Injury	Work?	28d. Describe how in	ijury occurred	
isio	death death ctor: / y the f	icat	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury - At home, farm, s	M 1 Yes 2 No	28f. Location (Street	and Number or Bura	al Route Number
=	5 월 등 드	Certification;	4 Homicide determined	building, etc. (Specify)	sitest, factory, office	City or Town, St	ate)	ir riodio riambor,
	To the Hospital within 24 hours a To the Funerel Completely filled	Saic		sician: To the best of my knowledge, dea				
:	To the Horwithin 24 h	Aedicai	one) 2321	nar: On the basis of examination and/or i and manner stated.				
,	vithin To tha	Σ	29b. Signature and title of certifier	11 1	O.C.M.E		ARCH 11,	2006
	1		20 Name and address of account	empleted cause of death (tem 23a) (Type	) Print)			
	V		THE PORE MI	יות 111 דעדיי	NN STREET, BALTIMOI	RE, MARYLAN	D 21201	
	Sta	ate	31. Date filed (Month, Day, Year)	32. Registrar's Signature	M .			
	Regist		MAR 1 5 2006	State It Ages				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene U 5 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** Nannie D Grimes March 11, 2006 7:15a /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Mariner Health Care Prince George's Laurel If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 💢 F 100 Yrs. Oct. 25, Director 410-22-9039 Tennessee Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any hybry or other treumatic event, the Madical Examinational Examination at once. 10c. City. Town or Location 10a. State 10b. County 10d. Inside City Limits 1 ¥ Yes 2 □ No Directo Tennessee Dickson Dickson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 106 E Hunt Street 37055 United State America Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 전 No If Yes, Give Year or Dates: 14. Race - American Indian Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: White Š 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 House wife Owned Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be James T. Daniel 2 Louella Carroll 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marian Harris/Daughter 106 E Hunt Street, Dickson, Tennessee 37055 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Metro Crematory 4 ☐ Donation 5 ☐ Other (Specify) March 15, 2006 Catonsville, Maryland 22. Name and Address of Facility 21. Signature of Fun al Service Licensee Fleck Funeral Home Nullwan 7601 Sandy Spring Road Laurel, Maryland 20707 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Anterior Sclerotic Cardio Vascular Decease over 5 years /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Dualto (or as a consequence of) To the Hospitel or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicien end completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If ye's, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Day Month Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No s certificate has b lirector, page 2 si 1 Yes 2 💢 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other 4V Nursing Home 5 Residence 6 Other (Specify) ٩ 1 Yes 2 No 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of 28d. Describe how injury occurred Injury at Work? 1 Natural 2 Accident 5 Pending 1 Tes 2 No investigation 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D24721 March 15, 2006

DHMH 17 Rev 1/2001

State

Registrar

ORIGINAL

Syed Sadiq 14333 Laurel Bowie Road Suite 208, Laurel, Maryland 20708

32 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

MAR 1 5 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygierie 🗍 📋 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month **Physician** Lillie Gray-Pugh March 2006 4:08 p. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Gilchrist Towson If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Days Months Hours 1 ☐ M 2 🕏 F Director Nov. 25, 1910 Virginia 212-58-1064 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryla Department of Heelth and Mental Hygiene. Important: If them 27 is marked other than "natural", or itame 23s or 28s-1 show any injury or other traumatic event, the Madical Examinar must be notified an once. 1 ☐ Yes 2 ☑ No Director Maryland Baltimore Edgemere 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2855 Lodge Farm Road 21219 United States Funera 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? ☐Yes 2 f Yes, Give 2√ No 1 ☐ Never Married 25 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: White If Yes, Give Year or Dates: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker years Own Home 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be 2 Elzie L. Vest Minnie B. Swisher 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2855 Lodge Farm Road Edgemere, Maryland 21219 (Daughter) Mrs. Ramona Riazzi 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐Burial 2 ☐ Cremation 3 ☐ Removal from State 3/10/2006 Oak Lawn Cemetery 4 ☐Donation 5 ☐ Other (Specify) Baltimore, Maryland 22. Name and Address of Facility 21. Signature of uneral Service Licensee 7922 Wise Avenue Dundalk, Maryland 21222 Duda-Ruck Funeral Home of Dundalk, edon Approximate Interval Between Onset and Death 23a. Part1. Enter the drease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final ementin Physician ros disease or condition resulting in death) /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury Dua to for as a nonsequanna of) Examiner The law requires that the death certificate be executed burial-transit that initiated events nding physician and resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medicai use as the IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) of Vital Records, P.O. 9 Unknow 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown peeu 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an 2 No 1 ☐ Yes or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) NOSP Lee Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 No Certification; To 28a. Date of Injury (Month, Day Year) After thi 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Division 1/2 Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours effer death.
To the Funeral Director: A campletely filled in by the fu investigation 2 ☐ Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier March 8 2006 w 30. Name Ind do ess of person who completed cause of death (Item 23a) (Type, Print) Charles ST Bhomose un Zhay MACH 6601 N. CHARIES m 31. Date filed (Month, Day, Year) MAR 1 5 32 Registrar's Signature State Registrar DHMH 17 Rev 1/2001

**ORIGINAL** 

State of Maryland / Department of Health and Mental Hygiene For Stete Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** GROVER 9:18 FRANCES 2006 Merch /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** MANDE CARE NURSING AND REHAS NEWNOT BALTIMALE If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 ☐ M 2 🗗 F 86 Director 220-18-7551 04/13/1919 NC Usual Residence of Decedent death with the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits r than "natural", or items 23a or 28e-f show the Medical Example at most be notified at 1 ☐ Yes 2 No Director MD Baltimore Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2201 305 E. Joppa Road Apt. 21286 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 ► NO by 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Own Home Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 12 other other treumatic event, permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: If Item 27 is marked other eny injury or other treumstic avent 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be William Fraley Ada Belle Peebur 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ronald Norman Grover/step Son 7105 Harford Road Parkville, MD 21234 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Mar 11 \* 4 ☐ Donation 5 ☐ Other (Specify) Beltsville, Maryland Chesapeake Crematory Inc. 2006 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Cremation and Funeral Alternatives M01443 8717 Green Pastures Drive Baltimore, Maryland 21286-23a. Part. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician x hernic yens /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) Division of Vital Records. P.O. Box 68760. attending physician Completed by Physiclan/Medical as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 4 Pregnant at time of death 5 Other (specify) the detached 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an perform 21. No 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA 1 Yes 2 No Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred After the Hospitel or Attending 5 Pending investigation Natural death. 1 ☐ Yes 2 ☐ No after death 2 Accident the 3 🗌 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 Homicide within 24 hours a 29a. Certifier Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c License number D 58303 29b. Signature and tille of certifier 29d. Date signed (Month, Day, Year) March (0 h deress of person who completed cause of death (Item 23a) (Type, Print) Charles Grocer, baltmore no 21204 CHARVE N. WW 6601 A120N 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar

**ORIGINAL** 

DHMH 17 Rev 1/2001

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dete of Deeth 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month **Physician** 0 2006 Farl Cornelius Grabus Sr.
4e Fecility Neme (If not institution, give street end number) /Medical 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Harford Lorien of Bel Air 8. Date of Birth (Month, Dey, Yeer) POnder 24 Hrs. Birthplace (Stete or Foreign Country) If Under 1 Year 7. Age (In yrs. last birthdey) 5. Social Security Number **Funeral** Deys Months Hours 1XM 2□ F Maryland Director 218-03-7158
Usuel Residence of Decedent 11/23/1919 86 10d. Inside City Limits 10a. State 10c. City, Town or Location the Merylen 10b. County 1 ☐ Yes 2 No Director MD Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 21014 Funeral 115 Duncannon Road U.S.A. 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 1 1X Yes 2 □ No If Yes, Give Year or Dates: WW T T 14. Raca - American Indian, Black, White, etc. 1 Never Married 2 Merried Specify: White 1 ☐ Yes 2 X No Specify: 2 3 XWidowed 4 ☐ Divorced WW II altimore, Maryland 21215-00 Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elementery/Secondary (0-12) College (1-4or 5+) Is marked other than 12 Vulcan Materials Supervisor/Foreman 18. Mother's Name (First, Middle, Maiden Surneme) 17. Father's Neme (First, Middle, Last) Be Andrew Grabus Cornelia Bell 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 115 Duncannon Road - Bel Air, Maryland 21014 Sharon M. Conn (daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 

Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 Dother (Specify) Holly Hill Memorial Gdns. 03/16/06 Baltimore, Maryland 22. Name and Address of Facility E. F. Lassahn Funeral Home, P.A. 21. Signature of Funeral Service Licansee 11750 Belair Road - Kingsville, Maryland 21087 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician /Medical Immediate Ceuse (Final disease or condition resulting in deeth) INFARCT (STROKE · ACUTE CEREBRAL Examiner Due to (or es a consequence of) or Attending Physician: The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (of as a consequence of) Division of Vital Records, P.O. Box 68760, by Physician/Medical Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown ATRIAL FIBRILLATION, HYPERTENSION, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? Completed SEIZURE DISORDER HYPERLIPIDEMIA 2 No 1 Tes 1 ☐ Yes 2 ☐ No Be 25. Wes case referred to medical exeminer? 26. Place of Deeth (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) ၉ 1 Yes 2 No this within 24 hours efter deeth.

To the Funeral Director: After this completely filled in by the funerel of 27. Menner of Death 28a. Date of Injury (Month, Dey Year) 28b. Time of Injury 28c. Injury et Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Naturel 2 Accident 1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 6 Could not be determined 3 Suicide 28e. Pleca of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date end pleca, end due to the ceuse(s) end manner as steted.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(s) and manner steted. edicai 29d. Date signed (Month, Dey, Year) 29c. License number 29b. Signature end title of cartifier 03/10/2006 D45344 eted cause of deeth (Item 23e) (Type, Print) 30. Name end eddless of person who con S. UNION AVE, HAVRE DE GRACE, MD 21078 SURESH DHANZA MA 622

Registrar **DHMH 16 Rev 6/95** 

State

31. Dete filed (Month, Day, Year)

32. Registrer's Signature

**ORIGINAL** 

		1	For State Registrar	State of Maryland		rtment of H tificate of L			ene 0 0 6	07866			
4,	<b>建筑图 *</b> .		Decedent's Name (First, Middle, Last)					2. Date of Deat Month	Day Yea				
	Physicia /Medic	al	Aubrey	Α.		Gotha	Location of Death	MARCH	4c. County of De				
	Examin	er	4a. Facility Name (If not institution, give str	TAN 105P17	AL		CTIMOR	S	NA	3441			
	Funeral	36"	5. Social Security Number 6. Sex	7. Age (In yrs. las	t birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year) 9. E	Birthplace (State or Foreign Country)			
à	Director		360 60 01.0	M 2XIF 77	Yrs.			10-22-	-28 V	West Indies			
	ow and	-	Usual Residence of Decedent  10a. State 10b. County	10c. City,	Town or Loc	ation				10d. Inside City Limits			
	a-fsh	ctor	Md. Baltimor	e	Tow	son				1X Yes 2 No			
	h with the	al Director	10e. Street and Number 8413 Loch Raven B	lvd. Apt. c		10f. Zip Code 2120			0g. Citizen of What USA	Country?			
39	2 should be filed within 72 hours after death with the Maryland and Menral Hygiene. Is marked other then "natural", or Items 23a or 28a-f show aumatic event, the Medical Examinationals be notified at	by Funeral	11. Marital Status  1 ☐ Never Married ② Married  3 ☐ Widowed 4 ☐ Divorced	2. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2X No If Yes, Give Year or Dates:	If	Vas Decedent of Hi Yes, specify Cuba □ Yes 🏋 No	spanic Origin? (Sp n, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	Black, W	merican Indian, /hite, etc. Black			
200	72 hou		15. Decedent's Educa (Specify only highest grade		(Give	ent's Usual Occupa	luring most of work		16b. Kind of Busine	ss/Industry			
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yla	narke	2	William  19a. Informant's Name/Relationship (Typ)						, City or Town, Stat				
Z	s 1 and 2 should I Health and Men item 27 Is marke other traumatic		Kathleen Gotha	Wife					Towson,				
Baltimore, Maryland	permit. Pages 1 and 2 Department of Health a Important: If item 27 It eny injury or other tra 2008.		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	moval from State 20b. Pla		Date 2-06	20c. Location - City St. John	or Town, State .s, Antigua					
Balti	permit. Departm Importa eny inju		21. Signature of Funeral Service Licensed	) and	ss of Facility H. East		imore, Md E. North						
ang str	N 101		23a. Part1. Enter the disease, or complic shock, or heart failure. List only one	ations that caused the death.	Do not ente	er the mode of dyin	g, such as cardiac	or respiratory arr	est,	Approximate Interval Between Onset and Death			
Title	Physician		Immediate Cause (Final disease or condition resulting in death)	PRESUMED		E HYOU	ARDIAL I	NFARCT					
	/Medical Examiner		Due to (or as a consequence of):  CHRONC OBSTRUCTIVE AIRWAY DISEASE										
B		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseque	ence of):								
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9	ing phy a as th	Medi	IF FEMALE:							1			
.O. Box	The law requires that the death certificate site has been signed by the attending physpage 2 should be detached for use as the	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	ac. If yes, outcome of pregnant  1 Live birth 2 □ Fetal of  4 □ Pregnant at time of dea  9 □ Unknown	death 3	Ectopic pregnancy Other (specify)	/		23d. Date of Month	Day Year			
Δ.	es that thigned by be detac	þ	Part II. Other significant conditions con	tributing to death but not resul	ting in the u	nderlying cause giv	en in Part I.		bacco use contribu	te to the cause of death?  Probably 4 Unknown			
of Vital Records,	w require been si should l	Completed						24a. Was	an 24b. Wer	e autopsy findings available			
Rec	The law sete has page 2 :	dmc						autop perfor	sy prior deat	to completion of cause of h? Yes 2 \sum No			
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> ₹	Physician: r this certificantal director, and director, an	2	1 ☐ Yes 2 🔀 No		R/Outpatier	IL SELDON			ence 6 Other (	Specify)			
	Jing After fune	tlon;	27. Manner of Death  1 Manural 5 ☐ Pending  2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	Wo	rk?  Yes 2 □No	200. 2000.00	on injury occurred				
Division	or Attendil Ifter death. Director: A in by the fu	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At hor building, etc. (Specify)		reet, factory, office		28f. Location (S City or Тои		or Rural Route Number,			
_	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Medical Ce	29a. Certifier 1 Certifying Phys (Check only 2 Medical Examir one)	ician: To the best of my knowner: On the basis of examinati and manner stated.	vledge, deat ion and/or in	h occurred at the ti vestigation, in my	me, date and place opinion, death occu	, and due to the oursel at the time,	cause(s) and manne date and place, and	or as stated. due to the cause(s)			
	ro the within of the comple	Me	29b. Signature and title of certifier			29c. Licen:	se number	29d. Date signed (Month, Day, Year)					
	- 3 - 0		1 & kazne	5 000		3/11/01	9						
-	\( \)	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  TZUKANTI SIKKZWE, 5601 WUT RAUEN BUD,							ORE MO	1. 21239			
1	St Regist	ate	31. Date filed (Month, Day, Year) MAR 1 5 20	32. Fegistrar's Signat	ure	and I							

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend unpend item# 23a, 26, 27, 28a-f, penME, 0853, 3/22/06 TT State of Maryland / Department of Health and Mental Hygiene 06-01819 Walter Hitt 1 - For State Registrar RJD Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death March 14, Day 2006 **Physician** Walter Hitt 0:20 A. M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Box 549 Md. 20764 Jessup Anne Arunde1 If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day Year)

Win. (Month, Day 7959) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral**  Birthplace (State or Foreign Country) 1 XM 2 ☐ F Months 220-80-5022 Yrs. 46 Director Maryland Usual Residence of Decedent el the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral, or items 23a or 28a-f ahov Examinar must be notified at 1 ☐ Yes 2 🛣 No Dundalk MD. Baltimore Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? WITH permit. Pages 1 and 2 should be filed within 72 hours atter death v Deperment of Health and Mental Hygiene. Importent: If itam 27 Is marked other than "natural", or Items 23s any Injury or other treumatic avant, the Medical Examinat rough. 21222 USA 8164 Del Haven Road Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ▼No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: 3 ☐ Widowed 4 ☑ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Welder Shipyard 10 years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Frances Sponaugle Olin E. Hitt Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8164 Del Haven Road, Dundalk, Md. 21222 Olin E. Hitt Sr. Father 20b. Place of Disposition (Name of 20a. Method of Disposition March 18, 20c. Location - City or Town, State nlace) 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Oak Lawn Cemetery 2006 Dundalk, MD. 21. Signature of Funeral Service Licenses <sup>22. Name and Address of Facility</sup>
Connelly Funeral Home Of Dundalk, P.A.
7110 Sollers Point Road, Dundalk, Md. 21222 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiralory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Priysician Narcotic intoxication /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a gonseculance offi-Examiner attending physician and for use as the burial-transit or Attanding Physician: The law requires that the death certificate be executed Due to (or as a consequence of): ivision of Vital Records, P.O. Box 68760. Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐ Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown been si **Be Completed** 24a. Was an autopsy performed? раде certificate Yes 2 No 26. Place of Death (Check funeral director 25. Was case referred to medical Hospital: 1 | Inpatient Other: 4 Nursing Home 5 Residence 6 Nother (Specify) At Scene Certification: To 1X Yes 2 □ No 2 X ER/Outpatient 3□ DOA 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 1 Natural 5 Pending death. М 1 ☐ Yes 2 🕱 No investigation 2 Accident 3/13/2006 within 24 hours after death To the Funeral Director: completely filled in by the unk 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Maryland house of Correction Jessup, MD 4 - Homicide Correction Jessup, tha Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only 29b. Signa and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. March 14, 2006 oddeath (Nem 23a) (Type, Print) 111 Penn Street, Baltimore Maryland 21201 UN 32. 31. Date filed (Month, Day, Year) Registrar's Signature State Barre S Registrar 5 2006

State of Maryland / Department of Health and Mental Hygiene [1] [6] 1 - For State Registrar Certificate of Death 2 Date of Death . Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** PM 10 Hetrick 2006 /Medical 4b. City, Town, or Location of Death 4c. County of Death Eacility Name (If not institution, give street and number) **Examiner** If Under 24 If Under Year 5. Social Security Number 6. Sax 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year, Birthplace (State or Foreign Country) **Funeral** Days Months MM 20F Yrs Director 218-32-8193 70 22,1935 April Maryland Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a. State 10b. County 10d, Inside City Limits 28a-f show other treumstic event, the Medical Examiner must be notified at MD 1 ☐ Yes 2 No Director Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with ŏ 1305 Midvale Avenue 21228 or Items 23a USA death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 and 2 should be filed within 72 hours after of Health and Mental Hygiene. Health and Mental Hygiene. em 27 is marked other than "naturel", or Iter 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: White ð 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4or 5+) 5+ Elementary/Secondary (0-12) Veteranarian Small Animal Medicine 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) John M. Hetrick, Sr. Donna Carter Dulany 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Importent: If item 27 is any Injury or other tree 1305 Midvale Avenue; Catonsville, MD 21228 Marjorie C. Hetrick Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Metro Crematory 3-13-2006 Baltimore, Maryland 22. Name and Address of Facility Sterling-Ashton-Schwab-Witzke Funeral Home of Catons Ville, Inc. MD 21228 21. Signature of Funeral Service License 1630 Edmondson Avenue; Catonsville, MD 21228 m 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician ear disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, any leasn's Long Cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to [or as a consequence of]: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, burial-tran Due to (or as a consequence of): attending physician for use as the buria Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month in the past 12 months? Day 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No ed by the detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ be 1 Tyes 2X No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy 1 ☐ Yes 2 ☐ No 1 Yes or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 2 00 Cther 1 🗌 Inpatient Certification: To 1 🗌 Yes 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manger of Death 28d. Describe how injury occurred 1 Natural 5 Pending investigation after death. 1 ☐ Yes 2 ☐ No ☐ Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours a Hospitel 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Dey, Year) 29b. Signature and title-of 29c. License number March 13 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Eldersbury MD 21784 Miam Tan Mo 1645 32) Registrar's Signature 31. Date filed (Month, Day, Year) State 5 2006 Registra

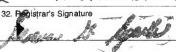
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	Dhuaisi		1. Decedent's Name (First, Middle, Last)						2.	Date of Death Month	Day	Year	3. Time of Death	
	Physici /Medio		Rose Marie Howard						1	AREH	with more the way	006	120 b	М
1	Examin		4a. Facility Name (If not institution, give s	street and number)		4b. City, T	rown, or L	ocation of D	Death	gen	4c. County	of Death	,	
			Partinose loss		eduil	an.	6/4	20/32	wall	e	Ann	re A	RUNDIE C	
	Funeral		5. Social Security Number 6. Sex 212-32-2180	7. Age (In	yrs. last birthday) 71 Yrs.	If Under 1 Months		If Under 24 Hours I	Min.	Date of Birth (Month, Day,	Year)	Cour		ign
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	r 28a	Director	10e. Street and Number			10f. Zip (	Code			10	g. Citizen of V	Vhat Cour	itry?	
	within 72 hours after death with the Maryland ene. then "natural", or itema 23a or 28a-f ehow the Madical Examinat must be notilliad at		1603 Sunshine Stre	et		2106	61			U.	.S.A.			
	dea	Funerai	11. Marital Status	12. Was Decedent Ever Armed Forces?	in U.S. 13.	Was Decede	ent of Hisp	anic Origin	? (Specify	Yes or No-		e - Americ		
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р Б	Hygir ther		17. Father's Name (First, Middle, Last)		nome	maker	1.	8. Mother's	Name (F		Wn Hom laiden Sumam			
Maryland 21215-0036	d be antal	o Be	John Able Dyson								Thompso			
<u> </u>	shoul mari	ဥ	19a. Informant's Name/Relationship (Ty)	pe, Print)	19b. Maili	na Address		-			City or Town,		Code)	
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ē,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. In Intercent: if item 27 is marked other than "natural; or itema 23a or 28a-1 show amy njury or other traumatic event, the Madical Examinat must be notified at ancie.		20a. Method of Disposition	20	b. Place of Dispo	sition (Name	e of		Date		Oc. Location -			
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Division of Vital Record	after of At Direct	Certification:	4 Homicide determined	28e. Place of Injury - building, etc. (S)	At home, farm, str oecify)	eet, factory,	office		28f.	Location (Streetity or Town,	eet and Numb State)	er or Rura	l Route Number,	
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	To the Hospital or Attending Physician: within 24 hours after death as a feet death To the Funeral Director. After this certific completely filled in by the funeral director.	Medical	(Check only one)	sician: To the best of my ner: On the basis of exa- and manner stated.	nination and/or in	n occurred a vestigation, i	it the time, in my opin	ion, death o	occurred a	at the time, da	use(s) and ma te and place, a	nner as st and due to	ated. the cause(s)	
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	1		30. Name and address of person who co	mpleted cause of death	(Item 23a) (Type,	Print)	an.		10	Alu D	710C	4	200	
	- 1		30. Name and address of person who co	ESPETITE.	Drove		-lan	Ten	111	e an	3 20	106		
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

Amend 1 tem 26 per verb \$853 3-15-06 vt
State of Maryland Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month 13-2006 **Physician** 9:40AM Handelman Alma /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Manchester Carroll Longview Nursing Home | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | NOV . | 19, 1913 5. Social Security Number 9. Birthplace (State or Foreign Country)
Phila., PA 7. Age (In yrs. last birthday) 6. Sex **Funeral** Months 1□M 257F 92 221-03-7410 Director Usual Residence of Decedent parmit. Pagas 1 and 2 should be filad within 72 hours aftar death with the Maryland Department of Health and Martial Hygians. Important: if item 27 is marked other than \*natural', or items 23a or 28a-f show any injury or other traumatic event, The Macifical Examiner must be ricitized at 10a. State 10c. City, Town or Location 10b County 10d. Inside City Limits 1 ☐ Yes 2 XNo Director Baltimore Reisterstown 10f. Zip Code 10e Street and Number 10g. Citizen of What Country? 229 Chartley Drive 21136 U.S.A. Funerai 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2X No If Yes, Give 1 ☐ Yes 2 ☐ No Specify: Specify: White <u>ک</u> 3√ Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry DE State Dept. Elementary/Secondary (0-12) College (1-4or 5+) Of Labor Claims Deputy 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) æ Frederick Weisberg Sarah Spegiel 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 229 Chartley Dr., Reisterstown, MD 21136 Fred A. Handelman -Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Surial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Machzikey Hadas Cem. 2/16/06 New Castle, DE 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Schoenberg Memorial Chapel 519 Philadelphia Pike, Wilm., DE 19809 23a. Part 1. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or beart failure. List only one ceuse on each line. Approximate Interval Between Onset and Deat Physician Immediate Cause (Final disease or condition resulting in death) /Medical Cardiomtopathy Examiner Due to (or as a consequence of): Examiner attanding physician and for usa as tha burial-transit Tha law raquiras that tha daath cartificata ba axecutad Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Due to (or as a consequence of): Attar this cartificata has baan signad by tha a funaral director, paga 2 should ba datached is Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Dld tobacco use contribute to the cause of death? 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown CAD, ģ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: Certification: To 1 ☐ Yes 2X No Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No daath. s aftar daath 2 Accident investigation complataly fillad in by tha 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide Hospitai 24 hours a 29a. Certifier (Check only one) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, dete and place, and due to the ceuse(s) end manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) afanswr D 51705 3-13-06 NAME 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hestminster, my 21157. 1201) M. PANSURIYA DR malwim

State Registrar 31. Date filed (Month, Day, Year)

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3altimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760.

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	yland		10a. State 10b. County	1	Oc. City, Town or	Location	-			10d. Inside City Limits		
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	within 72 hours after death with the Maryland ene. then "netural", or Items 23a or 28a-f ehow fra Madical Exarili at frast be rudified at	Funeral Director	11. Marital Status	12. Was Decedent Ev Armed Forces?	er in U.S. 1	<ol><li>Was Decedent of Hi If Yes, specify Cuba</li></ol>	ispanic Origin? n, Mexican, Pu	(Specify Yes or No- erto Rican, etc.)	14. Race - Ar Black, Wi	nencan Indian,		
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Baltimore, Maryland	should ind Men	-	19a. Informant's Name/Relationship (			ailing Address (Street a		Rural Route Number, City or Town, State, Zip Code)				
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Вох	attend for us	lan	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of 1 Live birth 2	Fetal death	3 □Ectopic pregnancy			23d. Date of d Month	elivery Day Year		
<u>Ф</u> О	the de	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at tir 9□Unknown	ne or death	5 Other (specify)						
مــَ	res that the de signed by the a be detached f		Part II. Other significant conditions	ontributing to death but	not resulting in the	underiving cause give	en in Part I.	23e. Did tobacc	o use contribute	to the cause of death?		
g	uires sign Id be	d by	CHRONIC BENA		_					Srobably 4 Unknown		
ò	v require been signature should t	lete						24a. Was an	24h Word	outoniu finalina audietii		
æ	The law cete has page 2 s	Completed						autopsy	l prior to	autopsy findings available completion of cause of		
Division of Vital Records,	iician: Th certificete rector, pag	e C	25. Was case referred to medical				00.01	1  Yes 2	No 1 □ Ye	es 2 14 170		
5	Attending Physician: or death. ector: After this certifice by the funeral director, p	0 8	examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpatient	2 ER/Outpat	ont 30 DOA Othe	_	eath (Check only one) Home 5 Residence	2 □0th /0-			
ō	Phy er this	-	27. Manner of Death	28a. Date of Injury	28b. Time	of 28c. Injury		28d. Describe how in		iecity)		
<u>0</u>	tending Ph leath. Ior: After th the funeral	atio	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigatio	(Month, Day')	<i>'ear)</i> Injur		<br Yes 2 □ No		•			
N N	or Attendation death Director: in by the	Hc	3 Suicide 6 Could not be determined	286. Place of Injury	· At home, farm,	street, factory, office		28f. Location (Street	and Number or I	Rural Route Number,		
	s after d al Direct ad in by	Certification:	4   Homicide	building, etc.	(Брөспу)			City or Town, Si	ate)			
	To the Hospital within 24 hours a To the Funeral I completely filled	edical (	29a. Certifier 1 Certifying Pt (Check only 2 Medical Example)	ysician: To the best of miner: On the basis of ex	my knowledge, de	eath occurred at the time	ne, date and pla	ce, and due to the cause	e(s) and manner a	as stated.		
	To the Ho within 24 I To the Fu completely	Med	Uner,	and manner state	d.							
	5 1 N		29b. Signature and title of certifier	/ /		29c. License	number	29d.	Date signed (Moi	nth, Day, Year)		
	١		Junton 4	mosh			632	n	MARCH	13 2006		
	1		30. Name and address of person who	1								
			JENNIFER HAYAS  31. Date filed (Month, Day, Year)	32 Registrar's	HOPKINS Signature	BAYVIEW C	IRCLE,	BALTIME	JE WI	21224		
	Sta Registr		, , , ,	32 Hegistrars	o Signature	and a						
	MH 17 Rev 1/2	100	MAR 1 5 200	5 Person	M. A	EAST.		117				

ORIGINAL

NOUHOU H. INTI 06-01648 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. RJUnpend item#23a,27, pen/E, 853,3/18/06 TT Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death d **Physician** March 6, 8:24p. 2006 Nouhou Hasan Inti /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1330 Warwick Drive Baltimore Lutherville 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Pay, Year) 6-17-1955 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min 090-84-4702 1(XM 2□ F Yrs. Niger Director 50 Usual Residence of Decedent the Maryland 10a State 10h County 10c, City, Town or Location 10d. Inside City Limits or 28a-f ehow Examiner must be notified at Director Md Ba1to 1 ☐ Yes 2√☐ No Lutherville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21093 itema 23a 1330 Warwick Drive Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ŏ 1 ☐ Yes 2 No Specify: Specity: Completed by 3 ☐ Widowed 4 ☐ Divorced Black "naturai" the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation
(Give kind of work done during most of working Unk life. DO NOT use retired) 16b. Kind of Business/Industry Unk I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) N/A 12th grade other t 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be n and Mental I Hassan Inti Ala Ava 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Apt 166 Temple, Arizona 85281 Department of Health a important: If item 27 is any injury or other tra-1975 E. University Abdoulaye Sounaye - Cousin 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ➡ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Randallstown, Md King Memorial Park 3-12-2006 March F/II West 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 21215 4300 Wabash Avenue Balt, Md Irome pin 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Diabetic Ketoacidosis disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed nding physician and use as the burial-transit resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 Unknown been signed by should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, à 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has autopsy performed? certificate 2 🗆 No 1 ☐ Yes 2 No 1 ☐ Yes director Be 25. Was case referred to medical 28. Place of Death (Check only one) Hospital: Other: 4  $\square$  Nursing Home 5  $\square$  Residence 6  $\square$ Other (Specify) At SCENE Certification: To 1X Yes 2 □ No 1 Inpatient 2 ER/Outpatient 3 DOA After thi 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 XNatural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No Diractor: / 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours after d To the Funeral Diract completely filled in by

State Registrar

4 Homicide

29b. Signature and title of certifier

29a. Certifier

Medical

Southan, Jamela mi 31. Date filed (Month, Day, Year) MAR 1 5 2006

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32 Registrar's Signature

111 Penn Street

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number OCME

29d. Date signed (Month, Day, Year)

March 7, 2006

Baltimore, Maryland 21201

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		•	For State Registrer	State of Marylan	•	artment of H			iene g. No. 006	07874
		#.	Decedent's Name (First, Middle, Last)					2. Date of Deat Month	h Day Year	3. Time of Death
	Physici /Medic		VORIS	D.	J	ONES		MARCH (	6 2006	5:40A M
	Examin		4a. Facility Name (If not institution, give s PRINCE GEORGE S	HOSPITAL		4b. City, Town, or CHEVER			PRINCE G	EORGE'S
	Funeral Director		5. Social Security Number 6. Sex 577-64-1953	7. Age (In yrs. 64	Yrs.	Months Days	Hours Min		1942 9. Bir Co 16 SO	thplace (State or Foreign ountry) UTH CAROLINA
	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic avant, the Medical Examiner must be inclified at	Director	10a. State 10b. County  MD PRINCE GI		y, Town or Lo	DEN				10d. Inside City Limits 1    Yes 2   No
	with th	Dire	10e. Street and Number	A DIZITA SZ		10f. Zip Code 20706		10	0g. Citizen of What Co	ountry?
	er death Iteme 23	Funeral	8616 GLENARDEN PA	IZ. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 ☑ No	.S. 13. \	Was Decedent of H	ispanic Origin? ( In, Mexican, Pue	Specify Yes or No- rto Rican, etc.)	14. Race - Ame Black, Whit	
0036	hours aft ural', or	þ	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 Yes 2 No	Specify:		Specify:	BLACK
Baltimore, Maryland 21215-0036	within 72 ane. than "nat	Completed	15. Decedent's Edui (Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)  3 yrs	(Give	dent's Usual Occup kind of work done o DO NOT use retired ARMACY TE	during most of wo f)	prking	16b. Kind of Business PRIVATE	moustry
and 5	d be filed and land land land land land land land	Be	17. Father's Name (First, Middle, Last) ORLANDO DAVIS	<u> </u>	1		18. Mother's Na	me (First, Middle, A		
Mary	id 2 should the and Ment to the market traumatic a	ပ္	19a. Informant's Name/Relationship (Ty) SETH B. JONES/HUSE		19b. Mailir 8616	ng Address (Street	and Number or F EN PARKW	iural Route Number IAY GLENAF	City or Town, State, RDEN, MARYL	Zip Code) AND 20706
nore,	Pages 1 and nent of Health snt: If Item 27 ary or other to		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ R	emoval from State	emetery, crer	sition (Name of natory or other place OLN CEMET		, ,	20c. Location - City or	
Baltin	permit. Pages 1 and 2 Department of Health s Importent: If Item 27 It any injury or other tra ance.		4 Donation 5 Other (Specify)  21. Signatur of uneral Service License		22	. Name and Addre	ss of Facility J	. B. JENK	INS FUNERA R,MARYLAND	L HOME
	Physician /Medical Examiner		23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	e cause on each line.  CONGESTIVE  Due to (or as a conseq	HEART	FAILURE		ac or respiratory arre	est,	Approximate Interval Between Onset and Death
8760,4	cate be executed physician and the burial-transit	al Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	CONGESTIVE Due to (or as a conseq HYPERTENSI Due to (or as a conseq CARDIOPULM	ON uence of):		łY			
O. Box 6	ne death certifi the attending I thed for use as	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of d 9 □ Unknown	death 3	Ectopic pregnancy			23d. Date of de Month	livery Day Year
Ω.	quires that the signed by ald be detacted	Ď	Part II. Other significant conditions cor	tributing to death but not res	ulting in the u	nderlying cause giv	en in Part I.	1	paccoluse contribute to es 2□No 3□P	o the cause of death?
Division of Vital Records,	: The law requir cate has been si page 2 should	Completed						24a. Was al autops perforn 1 🗆 Yes 2	v prior to	utopsy findings available completion of cause of
Zi Si	Physicien: r this certificatal director, I	Be	25. Was case referred to medical examiner?	ospitaf:		oth Oth	or	eath (Check only on		
on of	ling Phye	lon: To	27. Manner of Death 1 XNatural 5 Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injur	4   Nursing		once 6 ⊡Other (Spe ow injury occurred	ecify)
Division	To the Hoepitel or Attending Physicien: The law within 24 hours after death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2	Certification;	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At he building, etc. (Specification)	ome, farm, str y)			28f. Location (St. City or Town	reet and Number or R n, State)	ural Route Number,
	To the Hoepitel within 24 hours a To the Funerel I completely filled	edical C		sician: To the best of my kno ner: On the basis of examina and manner stated.						
	To the within 2 To the complete	Me	29b. Signature and title of certifier	yseul	/	29c. Licens	e number -18 43		9d. Date signed (Mon	th, Day, Year)
7	(1		70.00	<del></del>	- 00-) 77 -		1075	•	5-7-	Ub
	0		30. Name and address of person who compared MUSHTAG SHAH 72	27 HANDOVER P	ARKWAY		GREENBE	LT,MARYLA	ND 20770	
	Sta Registi		31. Date filed (Month, Day, Year) MAR 1 5 200	32. Registrar's Signa	ture					

			1 - For Stata Registrar		ryland / D	epartment of Certificate of	Health and	Mental Hy	_	5 07875
*	Physic	ian	Decedent's Name (First, Middle, LELEANOR	ast) MARY		JACOBS		2. Date of De Month		3. Time of Death
	/Medi Examii Funeral Director		4a. Facility Name (If not institution, g Maryland Grey	ive street and number)	Spital Old yrs. last birth 80 YI	4b. City, Town,  Balti  day) If Under 1 Year  Months   Days		Irs. 8. Date of Bir	y, Year)	9. Birthplace (State or Foreign Country) MARYLAND
			Usual Residence of Decedent  10a. State 10b. County		100 City Town			10-11-	-1725	
	Marylan f ehow	ō		TIMORE	10c. City, Town		ASPEBURG	•		10d. Inside City Limits
	r 28a-	irect	10e. Street and Number	THOILE		10f. Zip Code	ADI DIDONG		10g. Citizen of W	
	23a o	aiD	5409 BUCKNELL RO	)AD			21206	4	U.S	S.A.
9036	72 hours after death with the Maryland natural", or iteme 23a or 28a-f show Jisal Exarcans trust be positifed at	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 ※ Widowed 4 □ Divorced	12. Was Decedent E Amed Forces? 1  Yes 2 X If Yes, Give Year or Dates:		13. Was Decedent of If Yes, specify Cut  1 ☐ Yes 2 【XNo		(Specify Yes or No erto Rican, etc.)	14. Race Black Specify:	- American Indian, , White, etc. WHITE
21215-0036	within ene. then	Completed	15. Decedent's (Specify only highest g Elementary/Secondary (0-12)	Education rade completed) College (1-4or 5-		ecedent's Usual Occu Give kind of work done ife. DO NOT use retire HOMEM	e during most of v ed)	working	16b. Kind of Bus	iness/Industry  N HOME
	be filed ital Hygie of other	Be	17. Father's Name (First, Middle, Las	it)			18. Mother's N	lame (First, Middle,	Maiden Sumame	)
Maryland	2 should be and Menta ie marked aumatic ex	မ	WILLIAM  19a. Informant's Name/Relationship		CHOEBERL		ELEA		(STAN	
Ma	12 s h ar 7 ie trau		BILL SCHOEBERLE			Mailing Address (Stree		RASPEBUE	·	21206
Baltimore,	nit. Pages 1 and artment of Healt ortant: if item 2 injury or other		20a. Method of Disposition 1	☐Removal from State	20b. Place of D cemetery,	isposition (Name of crematory or other plant  CEMETERY	ace)	Date 17–2006	20c. Location - (	City or Town, State
Balt	permit. Pag Department Important: any injury o		21. Signature of Funeral Service Lice	ensee ( hate	D>	22. Name and Addr 1211 CHES			DALE FUN SEDALE, M	ERAL HOME
8760,	Physician /Medical Examiner partial: (tausit partial: (ta	Icai Examiner	23a. Part . Enter the disease, or co shock, or heart failure. List onl Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Anemaca c. Anemaca c. Anemaca cause on each line and to for as a	consequence of	Ather vs Pneumo	cleros nia	is		Approximate Interval Between Onset and Death
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	20 90	Ď	Part II. Other significant conditions	contributing to death bu	t not resulting in t	ne underlying cause gi	ven in Part I.			oute to the cause of death?
al Records,	The ate h page	Completed							osy pr rmed? de	ere autopsy lindings available for to completion of cause of ath? Yes 2 \( \sumbole \text{No}
<u> </u>	Physician: Th this certificate ral director, pag	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital:			h	eath Check only o		
Division of Vital	ling Afte	Certification: To	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation			ne ol 28c. Inju	iry at	Home 5 Resid	dence 6 UOther	
ΩX	s after death s after death al Director:	Certific	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine		ry - At home, larm (Specify)	, street, factory, office		28t. Location (S City or Tox	Street and Number vn, State)	r or Rural Route Number,
	ne Hospital or n 24 hours after ne Funeral Dir bletely filled in	edical (	29a. Certifier 1 Cartifying F	hysician: To the best of miner: On the basis of and manner state	examination and/	death occurred at the to or investigation, in my	ime, date and pla opinion, death oc	ce, and due to the curred at the time,	cause(s) and mandate and place, an	ner as stated. Indidue to the cause(s)
)	To the To the complete	W	29b. Signature and title of certifier	~			se number 39568			(Month, Day, Year)
1	0		30. Name and address of person who	0. 40 7	Mary	and (	STENER	al H	pspita	L
	Sta Registr MH 17 Rev 1/2	ar	MAR 1 5 2	32. Registra	rs Signature	Soudis .				

ORIGINAL

icia		State Registrar     Decedent's Name (First, Middle, Last)		Cei	rtificate of	Death	2. Date of De	Reg. No		3. Time of Death				
		Ruth Marie Jester					Month March	Da						
dic		4a. Facility Name (If not institution, give s			4h City Town o	r Location of Death	March		. County of Deat	7:10 P.				
nine	er	Carroll County Ge	· ·	1	Westmi				Carroll					
ol.		Social Security Number 6. Sex			If Under 1 Year		8. Date of Bir	th	9. Birt	hplace (State or Forei				
al or			м 2 <del>Q</del> F 85	Yrs.	Months Days	Hours Min.	Jan. 25	y, Year)	Co	land				
		10a. State 10b. County	10c. City	, Town or Lo	ocation					10d. Inside City Limit				
SUCE.	ģ	Maryland Carroll	We	stmins	ster					1 ☐ Yes 2 🛣 N				
	Directo	10e. Street and Number			10f. Zip Code			10g. Cit	izen of What Co	untry?				
		200 St. Luke Circle	<u>.</u>		211	58			USA					
	Funeral		12. Was Decedent Ever in U. Armed Forces?	S. 13.	Was Decedent of H	lispanic Origin? (Sp	ecify Yes or No		14. Race - Ame					
1	ᇎ	1 Never Married 2 Married	1 ☐ Yes 2 🔯 No			an, Mexican, Puerto	Hican, etc.)		Black, White					
	ğ	3 X Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 🙀 No	Specify:			Specify: Wh	ite				
	etec	15. Decedent's Edu (Specify only highest grade	cation completed)	16a. Deced	dent's Usual Occup	ation during most of work	ina	16b. K	ind of Business/I	ndustry				
1	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life. I	DO NOT use retire	d)	y							
	ပ္ပ	11		Homen	naker				vn Home					
- 10	Be	17. Father's Name (First, Middle, Last)				18. Mother's Nam	e (First, Middle	, Maiden	Sumame)					
	ဥ	Grover Cleveland E	iney			Augus	ta Knop	h						
1		19a. Informant's Name/Relationship (Type	oe, Print)	19b. Mailir	ng Address (Street	and Number or Rur	al Route Numb	er, City o	or Town, State, Z	ip Code)				
1	J	Barbara Hancock	Daughter	1520	Wheat Dr	ive; Fink								
	-	20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ R		lace of Dispo emetery, cren	sition (Name of matory or other place		Date	20c. Lo	ocation - City or	Fown, State				
1		4 □Donation 5 □Other (Specify)	Loud	don Pa	rk Cemete	ery 3/17	/2006	Balt	imore, 1	Maryland				
1		21. Signature of Funeral Service Licenses 22. Name and Address of Facility Sterling Ashton Schwab Witzk Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue; Catonsville, MD 2122												
8		Damand	Ralwess	wi !	funeral H  630 Edmo	ome of Ca	tonsvil	le,	nc.	MD 21228				
		23a. Part1. Enter the disease, or compli- shock, or heart failure. List only on	cations that caused the death	. Do not ent	er the mode of dyir	ng, such as cardiac	or respiratory a	rrest,	,	Approximate Interval Between				
,		Immediate Cause (Final	Rilata		Pnoi	f b a NSa	,			Onset and Death				
ı		disease or condition resulting in death)	Due to (or as a consequ	ience of):	1110	imon	9							
1			Duch	10000	e <sup>10</sup>									
	ē	Sequentially list conditions	Due to (or a a con - u	ence of .	leading to immediate  b. Due to (or as a consequence of									
1.	ner	if any, leading to immediate												
	E	cause. Enter Underlying Cause (Disease or injury	Cause (Disease or injury that initiated events c.											
	Exam	cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequ											
	al Examin	cause. Enter Underlying Cause (Disease or injury that initiated events		ience of):	cle Pa	ien								
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	<u>a</u>	cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of the consequence of t	ience of):	ck pa	ieη			22d Date of dela					
1	<u>a</u>	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	Due to (or as a consequence of the consequence of t	nence of):	Ectopic pregnancy				23d. Date of delin Month	very Day Year				
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DHMH 17 Rev 1/2001

MAR 1 5 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 07878 State of Maryland / Department of Health and Mental Hygiene 🗍 Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) 3. Time of Death Month **Physician** Joseph Edward Keelan March 10, 2006 11:15P /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner N/A Joseph Richey Hospice Baltimore City If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 1 M 2□F 214-22-5217 78 Yrs. 04/19/1927 Director Maryland Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Items 23s or 28s-f ehow the Medical Examinar must be notified at 1 ☐ Yes 2 No Director Ellicott City Maryland Howard 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21042 2817 Southview Road United Stated filed within 72 hours after death 12. Was Decedent Ever in U.S. Amped Forces? 1 M Yes 2 □ No If Yes, Give Year or Dates: WWII 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No þ 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Il Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Regional Manager Recording Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Peges 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any injury or other traumatic event 500.68. Be Francis Xavier Keelan Rhoda Lauten 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kelly Shanahan - Daughter 1216 Turnberry Court Pasadena, Maryland 21122 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition cometery, crematory or other place)
Crownsville
Veterans Cemetery Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 03/16/2006 Crownsville, Maryland 22. Name and Address of Facility
David J. Weber Funeral Homes P.A.
5311 Edmondson Avenue Baltimore, Maryland 21229 21. Signature of Funeral Service Licensee athleen Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. fmmediate Cause (Final disease or condition resulting in death) **Physician** Urrhoses + morelles /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any loading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to [or as a consequence of]: Examiner Due to (or as a consequence of): 大なの「なっ Vital Records, P.O. Box 68760 Be Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? desen 1 ☐ Yes 2 🗖 Ño 3 ☐ Probably 4 ☐ Unknown Coronary arlery 24b. Were autopsy findings available prior to completion of cause of death? + resultant amideron 24a. Was an autopsy performed? 2 No 1 ☐ Yes 2 ☐ No 1∐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 MOther (Specify) Certification: To 1 ☐ Yes 2X No 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c, Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No Director: / 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide To the Hospital within 24 hours a To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Dwilliam Senedit. Mr. 3111/06 D008583

DXI

GWILLAM BENEDICT, MD, 150 W.LANVALEST., 31. Date filed (Month, Day, Year) State Registrar

32. Registrar's Signature

MAR 1 5 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ORIGINAL

BALTIMORR. MD 21217-4/20

			1 - For Stete Registrer	State of I	Marylar		artmen rtificat			nd M		giene	006	07879
	Physic /Medi		1. Decedent's Name (First, Middle, Mildred	Loether							2. Date of Dea		Year	3. Time of Death 3:20pmM
	Examii		4a. Facility Name (If not institution, Brighton Garder  5. Social Security Number	ns			Ве	Town, or					ounty of Death	mery
	Funeral Director		203-12-2180 Usual Residence of Decedent	5. Sex 7. 1 ☐ M 2 🔀 F	81	last birthday) Yrs.	Months	Days	If Under 2	Min.	8. Date of Birt (Month, Day 11-06	1924	9. Birth Cor	nplace (State or Foreign unity) hio
	Maryland a-f ehow	ctor	MD 10b. County MD Mont	gomery	10c. Ci	ty, Town or Lo Rockvi								10d. Inside City Limits 1 ☐ Yes 2 ☒ No
	th with the 23a or 28 ret be no	Funeral Director	10e. Street and Number 5550 Tuckerman	Lane #337	,		10f. Zip	Code	2085	2		10g. Citizer	of What Cou	untry?
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Items 23e or 28e-f ehow empt injury or other traumatic event, the Medical Examinar must be notified at ance.	þ	11. Marital Status  1 Never Married 2 Marrie  3X Widowed 4 Divorced	12. Was Decede Armed Force d 1 Yes 21 If Yes, Give Year or Date	s? ∑No		Was Deced f Yes, spec 1 ☐ Yes 2		spanic Origi n, Mexican, Specify:	in? (Spec Puerto F	cify Yes or No- Rican, etc.)		Race - Amer Black, White ecity: Wh	
Maryland 21215-0036	within 72 ho lene. than "natur the Madical	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12) 1 2	Education grade completed) College (1-4d	or 5+)		dent's Usua kind of wor DO NOT us tal H	k done d e retired)	uring most o	of workin	g		of Business/In	,
yland 2	ould be filed Mental Hyg arked other atic event, I	To Be C	17. Father's Name (First, Middle, La Unknown	ast)					18. Mother	s Name nown	(First, Middle,			JIICe
e, Mar	1 and 2 sho Health and em 27 is m		Jeff Loether/so		20b. F	1214	Autr	e Ct		kvil	Route Number	0851	own, State, Zi	
Baltimore,	mit. Pages bartment of bortant: if It injury or o		20a. Method of Disposition  1									Be1t	sville	
ä E	eny eny		23a. Part1. Enter the disease, or co	r Sprin	g MD	ice 20910	Approximate							
68760,	death certificate be executed  By America and Control of the Contr	dical Examiner	shock, or heart failure. List or Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to minimizate cause. Enter Underlying Cause (Disease or injury that intitated events resulting in death) Last	a. Cardiac Arrest  Due to (or as a consequence of):  Aspiration Pneumonia  Due to (or as a consequence of):  Hypertension  Due to (or as a consequence of):  Anemia										Interval Between Onset and Death
O. Box	death certi e ettending id for use a	Completed by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes ≥₹5No 9 □ Unknown	23c. If yes, outcom 1 ☐ Live birth 4 ☐ Pregnant 9 ☐ Unknown	2 Feta	I death 3	Ectopic pre Other (spe					23d.	Date of delive	ery Day Year
Records, P.	The law requires that the te has been signed by th vage 2 should be detached.	ted by Ph	Part II. Other significant conditions Alzheimer † s	s contributing to death	but not res	ulting in the un	derlying ca	use giver	n in Part I.			bacco use o		he cause of death?
_	@ LAL		25. Was case referred to medical							_		ned? ∑∰No	b. Were auto prior to co death? 1 \(\sum \text{Yes}\)	opsy findings available impletion of cause of
		o Be	examiner? 1 ☐ Yes 2 ➡ No	Hospital:	·	FD/0	• T 00	1 04-			Check only on	-		
	ding h. After fune	H- 1	27. Manner of Death  1 Tanatural 5 Pending 2 Accident investigat	28a. Date of In (Month, D	28a. Date of Injury (Month, Day Year)  28b. Time of Injury at Work?					28	5 ☐ Reside			(y)
DIVISION	i git o	Certification;	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	ed 289. Place of I building,	etc. (Specif)	()					City or Town	n, State)		al Route Number,
	To the Hospital within 24 hours a To the Funeral i completely filled	Medicai	one)	Physicien: To the bes eminer: On the basis and manner:	UI GAAIIIIIIa	wledge, death tion and/or inv	occurred a estigation,	t the time	, date and p nion, death	occurred	d due to the call at the time, da	ause(s) and ate and plac	manner as si	tated. o the cause(s)
	7 viii	2	29b. Signature and title of certifier	dy				License i	53691		2		gned <i>(Month,</i> . 3–2006	
	N		30. Name and address of person wh Ajay Reddy MD 63					MD	20817					
*	Sta Registr		31. Date filed (Month, Day, Year) MAR 1 5 2	006 <b>32</b> . Regis	trar's Signa	ture	No.							

Dung Luong 06-01822 NJM

			1 = For State Registrar	State of Ma	ryland / Dep <i>Ce</i>	artmen rtificat			nd Me		giene leg. No.	06	0788	0
	Physic		Decedent's Name (First, Middle, Last,     Dung Van Luong	1						2. Date of Dea Month March	Day 14	2006	3. Time of De. 1040	ath M
	/Medi Exami		4a. Facility Name (If not institution, give Sinai Hospital	street and number)		4b. City,		Location of C		RIL CII		unty of Death	1040	
	Funeral Director		5. Social Security Number 6. Set 15  **None**  Usual Residence of Decedent	M 2DE	(In yrs. last birthday, 43 Yrs.	If Under Months	1 Year Days	If Under 24 Hours	Min.	Date of Birth (Month, Day ept.1,	, Year)	9. Birthp Cour Viet		reign
	the Maryland 28a-f ehow	Director	10a. State 10b. County  Maryland Baltimor  10e. Street and Number	e	10c. City, Town or L	11e							0d. Inside City L 1 ☐ Yes 2 §	
36	er death with Iteme 23a or ner must ke	by Funeral Dir	10 Adil Court	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates:			228 dent of Hi offy Cuba	spanic Origir n, Mexican, F Specity:	n? (Speci Puerto Ri	fy Yes or No- can, etc.)	Viet	Nam Race - Americ Black, White,	an Indian,	
21215-0036	within 72 hours aft ene. then "naturel", or re Medical Exemi	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	cation	) (Give	DO NOT us	rk done a se retired,	uring most of	f working		16b. Kind o	of Business/Ind		
73	Ø 4 5 8	To Be Co	Unk 17. Father's Name (First, Middle, Last) Luong Van Lanh		Neve	r Wor	ked		Name (i	First, Middle, I	None Maiden Sun	name)		
d)	and tealth m 27 her t		19a. Informant's Name/Relationship (Ty.  Tom Kimme1 Nep 20a. Method of Disposition 1□Burial 2□Cremation 3 🖾	hew		W. Sei	ninai ne of	ry Ave		Luther	rville	wn, State, Zip  MI) 7 on - City or To	1093	
Baltimore,	permit. Pages 1 Department of H Important: If ite any injury or ot once.		4 Donation 5 Other (Specify) 21. Signature of Euneral Service Lices	The Sha	Siagon,	Name and	d Addres L HOI	s of FacilityS ne of	terl Cato	ing Asi nsville	nton S	Schwab	Witzke	
	Physician /Medical /Medical /Medical Examiner	l Examiner	23a. Part1. Enter the disease, or complishock, or heart failure. List only or immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a	he death. Do not en	er the mode	e of dying	, such as ca	rdiac or r	espiratory arre	est,		Approximate Interval Betweer Onset and Deat	
.O. Box 68760,	death certificate e attending phy: id for use as the	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at til 9 □ Unknown	Fetal death 3	Ectopic pre						Date of deliver	ry Day Year	
ords, P	The law requires that the te has been signed by th vage 2 should be detache	þ	Part II. Other significant conditions con	tributing to death but	not resulting in the u	nderlying ca	use give	n in Part I.			acco use c		e cause of death	
		Completed	05. W						_	24a. Was ar autopsy perform 1 Yes 2	/	death?	sy findings availanderion of cause	able of
		To Be	25. Was case referred to medical examiner?  11 Yes 2 □ No	ospital:	2 XER/Outpatien	t 3 DO	Other	627.1		heck only one		Other (Specify,		
Division of	Attending Phys r death. ector: After this by the funeral di		27. Manner of Death  1 Natural 5 □ Pending 2 □ Accident investigation	28a. Date of Injury (Month, Day )	28b. Time of		Bc. Injury Work			l. Describe ho			)	
Divis	i Sign	Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	building, etc.						City or Town,	, State)		Route Number,	
	To the Hospital or All within 24 hours after or To the Funeral Direct completely filled in by	Medicai	29a. Certifier 1☐ Certifying Phys (Check only one)	er: On the best of er and manner state	kamination and/or inv	occurred a restigation,	it the time in my opi	e, date and pl nion, death o	lace, and	due to the ca at the time, da	use(s) and te and plac	manner as sta e, and due to	ited. the cause(s)	
	C T Will	~	29b. Signature and title of certifier	Poll	L ,s		License O(	number CME		29		ned <i>(Month, E</i>		
	2		30. Name and address of person who cor	npleted cause of dea	th (Item 23a) (Type,	_			eet	Baltin			nd 21201	L
1	Sta Registra		31. Date filed (Month, Day, Year) MAR 1 5 2005	82. Registrar's	Signature	Es.								

			1- State of Maryland / Dep	partment of Health and ertificate of Death	Mental Hygier	4UU0 U/001								
	Dhyoini		Decedent's Name (First, Middle, Last)		2 Date of Dooth	3. Time of Death								
	Physici /Medi		Warren C. Litsinger, Jr.		March of	75, 2006 10:30AM								
	Examir	ner	Baltimore Washington Midical	4b. City, Town, or Location of Dec		Anne Armal 1								
	Funeral Director		5. Social Security Number  6. Sex  1 M M 2 F  7. Age (In yrs. last birthda)  1 Vrs.	y) If Under'1 Year If Under 24 Hr Months Days Hours Mir	n. (Month, Day, Yea	9. Birthplace (State or Foreign Country) 925 Maryland								
	land m		Usual Residence of Decedent           10a. State         10b. County         10c. City, Town or I	Location		10d. Inside City Limits								
	Mary	to	Maryland Anne Arundel Lint	hicum		1 ☐ Yes 2X No								
	th the	irec	10e. Street and Number	10f. Zip Code	10g. C	Citizen of What Country?								
	th will	aip	508 LaClair Avenue	21090	t	JSA								
	r dea	Inel	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	. Was Decedent of Hispanic Origin? ( If Yes, specify Cuban, Mexican, Pue	Specify Yes or No-	14. Race - American Indian, Black, White, etc.								
36	rs afte	by Funeral Director	1 ☐ Never Married 2 ☆ Married 1 ☐ 🏋 Yes 2 ☐ No If Yes, Give 3 ☐ Widowed 4 ☐ Divorced Year or Dates: ₩₩ 📗	1 Yes 2 No Specify:	,,	Specify: White								
8	within 72 hours after death with the Maryland ene. then "natural", or items 23e or 28e-f show the Medical Exercitinal transities or relitied at	ed t	15. Decedent's Education 16a. Dec	edent's Usual Occupation	16h	Kind of Business fladuate.								
215	hin 72	Completed	(Specify only highest grade completed) (Giv Elementary/Secondary (0-12) College (1-4or 5+)	re kind of work done during most of w DO NOT use retired)	orking 100.	6b. Kind of Business/Industry								
7	ad wit	Com	12 Sel	f Employed	G	Games and Jukes								
Ind	be fit d oth	Be	17. Father's Name (First, Middle, Last)		ame (First, Middle, Maide	en Surname)								
돌	d Men narke	2			Hilda Haines									
, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examinating Insulate or other traumatic event, the Medical Examinating Insulates and ones.		19a. Informant's Name/Relationship (Type, Print)  Robert N. Litsinger Son 1011	ling Address (Street and Number or F 3 Carillon Court;	Rural Route Number, City Ellicott C	or Town, State, Zip Code) Sity, MD 21042								
Baltimore,	of He		20a. Method of Disposition 1 ☐ Burial 2 [X] Cremation 3 ☐ Removal from State 20b. Place of Disposition cemetary, cre	position (Name of ematory or other place)	Date 20c. I	Location - City or Town, State								
Ë	: Pag tment tant: jury c		4 □Donation 5 □Other (Specify) Metro Cr			onsville, Maryland								
Ba	Depar Depar impor any in		21. Signally a Funeral Very calicensee  Mol 290	22. Name and Address of Facility St Funeral Home of 630 Edmondson Ave	erling Asht Catonsvill	on Schwab Witzke e. Inc.								
			23a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or hear failure. List only one cause on each line.	nter the mode of dying, such as cardia	ac or respiratory arrest,	Approximate								
	Pnysician	8 17	Immediate Cause (Final disease or condition	Ke		Interval Between Onset and Death								
	/Medical Examiner		resulting in death)											
	Examiner	e	Sequentially list conditions, b.	7										
بلا	nsit	nine	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury	Fibrillatso. temsion										
7	icate be executed physicien and the burial-transit	Examine	that initiated events c. resulting in death) Last Due to (or as \( \) one quence of):		٧٦									
38760,	ysicie	dicai	d.											
_	ng ph	Jedi	IF FEMALE.											
XO2	death certifi e attending r d for use as	by Physician/Me		□Ectopic pregnancy □ Other (specify)		23d. Date of delivery  Month Day Year								
þ.	at the de by the a	hys	9 Unknown											
ŝ	law requires that the as been signed by th 2 should be detache		Part II. Other significant conditions contributing to death but not resulting in the t	underlying cause given in Part I.	23e. Did tobacco	use contribute to the cause of death?								
Ö	w require been sig should t	eted			1 ☐ Yes 2	Probably 4 □Unknown								
II Records,	The ate h page	Completed			24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?  1 ☐ Yes No								
VItal		Be	25. Was case referred to medical examiner?		ath Check only one	1								
5	S : D	<u>۽</u>	1 ☐ Yes 2 ☐ No ☐ 1 ☐ Inpatient 2 ☐ ER/Outpatie  27. Manner of Death 28a. Date of Injury 28b. Time of		Home 5 Residence									
0	Attending r death. sctor: After by the fune	tion	1-Natural 5 Pending (Month, Day Year) Injury 2 Accident investigation	of 28c. Injury at Work? M 1 ☐ Yes 2 ☐ No	28d. Describe how inju	iry occurred								
DIVISION	el or Attandir s after death. I Dirsctor: Af d in by the fur	ifica	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, st		28f. Location (Street a	nd Number or Rural Route Number.								
בֿ	spitel or Attending Ph ours after death. Peral Director: After th filled in by the funeral	Certification;	and it g, star (appearly)		City or Town, Stat	e)								
	To the Hospitel of within 24 hours af To the Funeral D completely filled in	edicai	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge deat a control on the basis of examination and/or in and manner stated.	th contined at the time, date and place exestigation, in my opinion, death occi-	a, and due to the cause(s urred at the time, date an	b) and marther as stated. d place, and due to the cause(s)								
	To th To th comp	Me	29b. Signature and title of certifier	29c. License number	29d. Da	ate signed (Mpnth, Day, Year)								
)		Н	, m)	1)48006	03	109/2006								
	6/1		30. Name and ad ss of person who completed cause of death (Item 23a) (Type,	Print)	-16la	a Romaid man								
	Stat Registra		31. Date filed (Month, Day, Year)  MAR 1 5 2006  32. Registrar's Signature	Carles										
	3 1 Togiotic		WILL TO COOL DESIGNATION OF THE PROPERTY OF TH											

		1 - For State Registrer	State of Marylan	d / Depa <i>Ce</i>	artment of I rtificate of	Health and Death	Mental Hy	giene	16	07882
		Decedent's Name (First, Middle, Last,	/				2. Date of De	eath Day	Year ,	3. Time of Death
Physic /Med		SONNIE	LEIGH	0			Man		2006	5.00/3 M
Exami		4a. Facility Name (If not institution, give				or Location of De	ath	4c. County	of Death	
		Millenium Healtho	are		Ellicot			Howa	rd	
Funera		5. Social Security Number 6. Se	7. Age (In yrs.		If Under 1 Year Months Days			rth ay, Year)	9. Birthpl Count	ace (State or Foreign
Director		207-32-4743	63	Yrs.				, 1942	Penn	sylvania
pur *		Usual Residence of Decedent  10a. State 10b. County	10c. Cit	y, Town or Lo	ecation				10	Od. Inside City Limits
sho	2	_								1 ☐ Yes 2 🖾 No
the N	ect	MD Howard  10e. Street and Number	EII	icott	10f. Zip Code			10g. Citizen of	Mhas Caus	
with	ō		- 1						Wilat Couri	.ry r
eath	Funeral Director	3000 North Ridge	ROACI 12. Was Decedent Ever in U.	S 13	21043 Was Decedent of I	Hispanic Origin?	Specify Yes or No	U.S.A.	e - America	an Indian
item item	'n	1 Never Married 2 Married	Armed Forces?		If Yes, specify Cub	an, Mexican, Pu	erto Rican, etc.)	Bla	ck, White, e	etc.
urs at	by	3 ☐ Widowed 4 ☑ Divorced	If Yes, Give Year or Dates:		1☐Yes 2☐No	Specify:		Specif	y: Whit	.e
2 hou	Completed	15. Decedent's Edu	cation		dent's Usual Occu			16b. Kind of B		
Z nic Z	pie	(Specify only highest grad Elementary/Secondary (0-12)	College (1-4or 5+)	life.	kind of work done DO NOT use retire	during most of word)	orking			
d with	E	12	College (1:40) 5+7	Sale	s Clerk			Depar	tment	Store
othe vant,	Be	17. Father's Name (First, Middle, Last)				18. Mother's N	ame (First, Middle	, Maiden Surnar	ne)	
Menta Aenta rked rice	ToE	Ralph Dill				Doroth	У		unl	known
should have		19a. Informant's Name/Relationship (T)	pe, Print)	19b. Mailir	ng Address (Street	t and Number or i	Rural Route Numb	er, City or Town	State, Zip	Code)
parmit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other treumetic event, the Medical Exprision must be notified at		David W. Boyko /s	on	1507	Terra O	aks Cour	t, Mt. A	iry, Ma	ryland	1 21771
of He item		20a. Method of Disposition 1 □ Burial 2 🖾 Cremation 3 □ F		lace of Dispo	sition (Name of natory or other pla	ice)	Date	20c. Location	City or Tov	wn, State
Page nent c		1 □ Burial 2 ☑ Cremation 3 □ F		Arunde	el Cremat	ory Mar	13, 06	Odenton	, Mar	vland
permit. Departminimporte any inju		21. Signal re 1 Funeral Service Licens		•	•					
		A MUTHES MILE	M00	773 3	onaldson 13 Talbo	tt Ave.	Home, P Laurel,	.A. Maryland	1 2070	7-4389
		23a. Part 1. Enter the disease, or compleshock, of heart failure. List only of								Approximate Interval Between
Physician		Immediate Cause (Final disease or condition	Disea	St	Onset and Death					
/Medical		resulting in death)	Due to (or as a conseq	uence of):	oric or	retto ou.	/ (	7 - 7 - 7		
Examiner			End Sto	ê Ge	Demo	entia				
	Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseq	uence of):						
cuted ransi	Examiner	liat illitated events	s							
an an arrial-t	EX	resulting in death) Last	Due to (or as a conseq	uence of):					1	
cate be executed physician and the burial-transit	dicai		d							
ng pt	Med	IF FEMALE:								
th cert	Physician/Me	23b. Was decedent pregnant	3c. If yes, outcome of pregna 1 Live birth 2 ☐ Feta		Ectopic pregnanc	:y			te of deliver	,
o dea	sici	in the past 12 months? 1 Yes 2 No	4 Pregnant at time of d 9 Unknown		Other (specify)			MIC	onth I	Day Year
at the	h	9 ☐ Unknowh '								
uies that the death certific signed by the attending f d be detached for use as	by 6	Part II. Other significant conditions co	ntributing to death but not res	ulting in the u	nderlying cause gr	ven in Part I.				e cause of death?
equires	ted						1 🗆	Yes 2□No	3 Proba	ubly 4 Unknown
as be	pie						24a. Was		Were autop	sy findings available
The The page	Completed						perfo	ormed2	death? 1 🗌 Yes :	
ien: rtiffica	Be	25. Was case referred to medical examiner?				26. Place of D	eath (Check only			
nysic nis ce dire	10	1 ☐ Yes 2 No	fospital: 1   Înpatient 2	ER/Outpatier	it 3 DOA Ott	her: 4X Nursing	Home 5 Resi	dence 6 Oth	er (Specify,	)
neral		27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	f 28c. Inju Wo		28d. Describe	how injury occur	red	
auth.	atic	2 Accident investigation		L	M 1	Yes 2 No				
r Atte	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At he building, etc. (Specif	ome, farm, str	eet, factory, office		28f. Location ( City or To	Street and Numb wn, State)	er or Rural	Route Number,
rs aff	Cer									
To the Hospitel or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	edicai	(Check only 2 Medical Exami	sician: To the best of my kno ner: On the basis of examina	wledge, deat tion and/or in	occurred at the tr	me, date and pla- opinion, death oc	e, and due to the curred at the time.	cause(s) and madate and place.	anner as sta and due to	ited. the cause(s)
the F the F the F	edi	one)	and manner stated.							
To To	Σ	29b. Signature and title of certifier			29c. Licen:		£.1	29d. Date signe	a (Month, E	ay, Year)
		> Claum				12000		March	12	1000
L		30. Name and address of person who co		23а) (Туре,	Print) D In	wat al	ok Da	ad Bo	Him	200 G on Mayland
7		Ramesh Sabapa 31. Date filed (Month, Day, Year)			CKRV	very Me	CK LOU	4 / "	71000	72124
Si Regis	tate trar	MAR 1 5 2006	a2.tRegistrar's Signa	- 4	M. a					

DHMH 17 Rev 1/2001

		Δm	end Item #16a&	Qa		-						Mental Hy	giene Reg. No.	16	07883
	Physicia	n	1. Decedent's Name (First, Mid	de, Las	t)	AN D		O OII				2. Dete of De Month	eth Dey	Year Zoo	3. Time of Death
	/Medica Examine		4e Fecility Neme (If not instituti						T	4b. City, To	own, or L	ocation of Deetl		y of Deeth	7.001
	Exa.		GENESIS BRIGHT							LUTHE	RVTI	l F	RA	LTIMO	RF
2	Funeral Director 8		5. Social Security Number 212-22-4033	6. Se		7. Age (In yi	rs. lest birthde Yrs.	Months	1 Year Days			8. Date of Bir (Month, Da 03/14/	th ly, Yeer)		plece (State or Foreign htry)
	*		Usual Residence of Decedent									00/14/	1722		110
	show		10a. State 10b. Count	у		10c.	City, Town or I	_ocetion						1	Od. Inside City Limits
	with the Merylan a or 28a-f show be notified at	20	MD BALT	MOR	<u>E</u>	В	ALTIMO								1 ☐ Yes 2 ☐ No
	with	Š	10e. Street end Number					10f. Zip					10g. Citizen of		ntry?
	eath	erai	33 STONEHENGE 11. Merital Status	CIR	12. Was Deced				1208	disposio Or	inin? (Cn	ecify Yes or No	U.S.	A. ce - Americ	on Indian
020	urs e	by Fu	1 Never Married 2 M Ma 3 Widowed 4 Divorce		Armed Ford 1 Y Yes 2 If Yes, Give Year or Da	ces?	0,3.	If Yes, spec	cify Cub	an, Mexical Specify:	n, Puerto	Rican, etc.)	Bla Specil	ck, White,	etc. HITE
215-0020	- 20	Completed	15. Decede (Specify only high	nt's Edu	le completed)		(Giv	edent's Usua e kind of wo 12001 TH	rk done	during mos	st of work	ring	16b. Kind of B	usiness/Ind	dustry
21,	d within giene. r than "	E	Elementary/Secondary (0-12)		College (1-	4or 5+)	MAN	UFACTO	R	EPRES	ENTA'	TIVE	FURN	ITURE	
pu	should be filed withing the Markel Hygiene marked other than matic event, the Markel M	Se C	17. Father's Neme (First, Middle	Lest)						18. Mothe	er's Nam	e (First, Middle,	Maiden Sumar	ne)	
yla	should b nd Mente marked umatic e	2	DAVID				L	AND		BE:	SSIE			S	IEGEL
Maryland	2 0 0		19a. Informant's Name/Relation HELEN LAND / I	ship (T)	ype, Print)							al Route Numbe			
	ges 1 and to Health if item 27 in other tr	- 1		ILFE		Lan				E CIR	CLE				MD 21208
Baltimore,			20a. Method of Disposition  1				Place of Disp cemetery, cre TIMORE	ematory or o	ther plac	сө)	03	Date 3/14/200	6 REIST		
Bal	permit. Page Department of Important: if any injury or phos.		21. Signature of Funeral Service	Licens	Two			22. Name an 3900 R	d Addre	ss of Facili TERST(	<sup>ty</sup> SOI DWN I	L LEVINS	SON & B PIKESVII	ROS., LLE,	INC. MD 21208
1	Bl		23a. Part1. Enter the disease, o shock, or heart failure. Lis	r compl only or	ications that car ne cause on ea	used the de ch line.	ath. Do not er	nter the mod	e of dyir	ng, such es	cardiac	or respiratory ar	rest,	1	Approximete Interval Between Onset and Death
-	Physician /Medical		Immediate Ceuse (Final disease or condition		00	-RIE	1250	a) (	^	100	A (7=	_		1	nonen
Car	Examiner		resulting in death)	é	a		(or as a conse		U	17 6	706			1.	,
1/	R # .				D. —	2001	4~c	ED	D	en	ens	TIA		1	noners
V	icete be executed physician end s the buriel-trensit	Adir	Sequentially list conditions,	r	·	Due to	(or as a conse	quence oi):						1	
68760,			Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	,	o	HAT	CUR	E .	70	711	RIV	IE		d	ays
587	phy:		that initiated events resulting in death) Last	1		Due to	(or as a conse	quence of):							
Box (				L,	d									<u> </u>	
	death certing e ettending ed for use e	5 ,	One II Other standing of the standard												
P.0.	the the school of the school o	֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓	Part II. Other significant conditi	ons con	tributing to deal	th but not re	sulting in the	underlying ca	ause giv	en in Part I					the cause of deeth?
	es that igned t											ישי	fes 2□ No	3 ☐ Prob	bably 4 Unknown
of Vital Records,	requir											24a. Wes a	an autopsy med?	ava	ere autopsy findings allable prior to appletion of cause
36	hes by					-								of c	deeth?
a	ician: The L certificete he rector, page											1 🗆 Y	es 2. No	1 [	Yes 2 No
<b>\rightarrow</b>	sician s certifi director	3	25. Was case referred to medica examiner?	1	lospital:		_		Oth	or.		(Check only o			
ō	Physician: r this certific oral director.	•  -	1 ☐ Yes 2 ☐ No 27. Manger of Deeth		1 ☐ Inp		☐ ER/Outpatie 28b. Time o		A	المه المعلق		me 5 Resid			")
0	ding th.		Valurel 5 ☐ Pendir 2 ☐ Accident investi		(Month,	Day Year)	Injury	м	8c. Injun Worl 1 □	k? Yes 2⊟ı		Lod. Describe fi	ow injury occur	100	
Division	tal or Attending P rs efter death. at Director: After t led in by the funers Certification:		3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	not be	28e. Plece of building	Injury - At I , etc. <i>(Sp</i> ec	home, farm, st ify)	reet, factory,	, office		- 1	28f. Location (S City or Tow		er or Rura	l Route Number,
	Hospi 4 hou Funer tely fil	2	29a. Certifier Certifyir (Check only one)	g Phys Examin	ician: To the be ner: On the basi and manner	s of exemin	owledge, deet ation end/or in	h occurred a vestigation,	at the tim in my op	ne, date and pinion, deat	d place, a	and due to the c ed at the time, c	ause(s) and ma date and place,	anner as sta and due to	ated. the cause(s)
_	within 2 To the comple		29b. Signeture end title of certifie	r				29c.	License	e number		2	29d. Date signe	d (Month, L	Day, Year)
	->-0		· Spe	phe	ZMD				^ -	( )	, , , , ,				
		3	0. Name and address of person	'	mpleted cause	of deeth (Ite	m 23e) (Tvne	Print)	0	١٥١١	ا ل	P. A.	111		Nh
	0		Shallvana		tust	096	m 23e) (Type,	ntro	10	ROO	ol,	Ca	Lumb	le	4D 21045
€° .ye	State	3	11. Date filed (Month, Day, Year)		32. Reg	istrer's Sign	ature	2 8							

DHMH 16 Rev 6/95

Registrar

MAR 1 5 2006

			1 - For State Registrar	State of Ma		/ Depa		t of H	ealth a	and M	lental Hy	giene () () Reg. No.		078	84
* £	Physici	an	Decedent's Name (First, Middle, Las								2. Date of De Month	ath Day	Year	3. Time of	Death
	/Medi	cal	Verna B.	Mays							March	9, 2006		6:17	A M
1	Examir	ier	4a. Facility Name (If not institution, give St. Mary's Hospi	-					Location of			4c. Count	y of Death Mary		
	Funcant	S .	5. Social Security Number 6. Second Security Number 6. Second Security Number 6. Second Security Number 6. Second		e (In yrs. ias	t birthday)	If Under		If Under		8. Date of Bir				r Foreign
1865)	Funeral: Director			□M 2X)F	88	Yrs.	Months	Days	Hours	Min.	Jan. 6	, 1918	Ker	place (State o intry) 1tucky	· · or organ
	P .		Usual Residence of Decedent										1		
	aryia shov	5	10a. State 10b. County		-	Town or Lo								10d. Inside Cit 1 ☐ Yes	
	the M	ect	Maryland St. Mary	's	Mech	anics	101. Zip					10- 01	140 - 1 0		-25
	with Sa or	2	27040 Oxley Drive					20659	9			10g. Citizen of U.S.A		intry ?	
	Jeath ms 23	era	11. Marital Status	12. Was Decedent I	Ever in U.S.	13. \				gin? (Spe	ecify Yes or No			ican Indian,	
20	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or Items 23e or 28e-1 show says injury or other treumatic event, tra Medical Enaction must be notified at ance.	by Funeral Director	1 Never Married 2 Married	Armed Forces?  1  Yes 2 1	No		fYes, spec 1 ☐ Yes			i, Puerto	ecify Yes or No Rican, etc.)	Special Special	ck, White	, etc.	
ğ	ural',	q p	3 X Widowed 4 □ Divorced	Year or Dates:									WII	ite —————	
ည်	n 72	lete	15. Decedent's Ed (Specify only highest gra	de completed)		16a. Deced (Give	dent's Usua kind of wor DO NOT us	rk done a	<i>uring</i> mosi	t of worki	ing	16b. Kind of E	Business/I	ndustry	
Maryland 21215-0036	withi	Completed	Elementary/Secondary (0-12)	College (1-4or 5	i+)		eachei					Educa	tion		
g	other other	Bec	17. Father's Name (First, Middle, Last)						18. Mothe	r's Name	(First, Middle,	Maiden Sumai	me)		
Jai	uld by Menta rrked	ToE	Amos Preston Ben	nett					Ma	ry E	. Benne	tt			
<u>a</u>	2 sho and is me		19a. Informant's Name/Relationship (7	уре, Print)		19b. Mailin	ng Address	(Street a	nd Numbe	er or Rura	al Route Numbe	er, City or Town	, State, Zi	p Code)	
≥ ~`	and ealth m 27 her tr		Dan Mays (Son)									le, MD			
gaitimore,	ges 1 if of H if ite or of		20a. Method of Disposition 1 △ Burial 2 ☐ Cremation 3 ☐	Removal from State		e of Dispo letery, cren					Date	20c. Location			
	it. Pa ritmen ritant: njury		4 □Donation 5 □ Other (Specify		Barb	ourvi						Barbour	ville		
מ	Depa Impo sny ir		21. Signature of Funeral Service Licent	Uncen		2F	Name and Hampto 25 E.	on Fi Cuml	inera perla	1 Ho nd G	me ap Pkwy	., Barb	ourv	409 ille, K	
			23a. Part1. Enter the disease, or compositions shock, or heart failure. List only	nna causa nn aach lir	10									Approximate Interval Bety	ween
	Physician		Immediate Cause (Final disease or condition	, A	Spi	May	LOV		P	ne	umo	m		Onset and D	)eath
	/Medical Examiner		resulting in death)	Due to (or as	a consequer	nce of):				٠	1-0				
		7	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	a	14P	0 X ) (	<u> </u>	u	esp	7	17000				
	uted I	nln	Cause (Disease or injury	500 (0) 00	a 00.7304001	100 017.				La	u un	D ,			
	be executed sicien and burial-transit	Examiner	that initiated events resulting in death) Last	C. Due to (or as	a consequer	nce of):									
700,	ate be nysicie he bur	cal	(	d											
ğ	ng ph		IF FEMALE:												
P.O. Box	res that the death certificate be executed igned by the attending physicien and be detached for use as the burial-transit	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 শ No 9 ☐ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal de	eath 3	Ectopic pro					1	ite of deliv onth		'ear
	The law requires that the ste has been signed by the page 2 should be detache	by Ph	Part II. Other significant conditions co	ontributing to death bu	ut not resulti	ຊg in the ur	nderlying ca	ause give	n in Part I.		23e. Did to	obacco use con	tribute to	the cause of de	eath?
Hecords,	quires n sign	d be	tuppi	wtens	100m						1 🗆 ነ	∕es 2⊠No	3 🗌 Pro	bably 4 🗆 U	nknown
္ဌ	aw require s been sig 2 should b	Completed	J								24a. Was		Were aut	opsy lindings a	available
	eician: The law certificate has t lirector, page 2 s	E			-						autop perfo	rmed?	death?	ompletion of ca 2□ No	use ol
2	ian: artifica ctor. p	Be C	25. Was case referred to medical examiner?					2.5010	26. Place	of Death	Check only o		7 2 703	20110	
>	Physic this ce	2	1 ☐ Yes 2 🛣 No		nt 2 EP	VOutpatien	t 3 DO	A Othe	r: 4 🗆 Nu	rsing Hor	me 5 🗆 Resid	lence 6 🗆 Oth	ner (Speci	fy)	
DIVISION OF VITAL	ing After une	Certification:	27. Manner of Death 1 X Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injur (Month, Day	Year) 28	3b. Time of Injury	M 28	Bc. Injury Work	at ? ′es 2 □ ì	2		now injury occur			
<u> </u>		tifica	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Inju	iry - At home	e, larm, stre	et, lactory	, office		- 1	28f. Location (S City or Tow	Street and Numl	ber or Rur	al Route Numb	oer,
2	nital or urs afte rai Dir lled in			1											
	To the Hospital within 24 hours a To the Funeral I completely filled	edical	29a. Certifier 1 X Certifying Phy (Check only one) 2 Medical Exam	rsicien: To the best of iner: On the basis of and manner sta	examination	edge, death n and/or inv	occurred a restigation,	at the time in my op	e, date and inion, deat	d place, a th occurre	and due to the e ed at the time,	cause(s) and made date and place,	anner as s and due t	stated. o the cause(s)	
	To the within To the comple	Ž	29b. Signature and title of certifier				29c.	License	number			29d. Date signe	d (Month,	Day, Year)	
3.00	1		MW	V.				D608	388		r I	March 9	, 20	06	
7	1			pleted cause of de			,	,	1	D 00	(2)				
	ar Surp. or		Rakhi Krishnan, 31. Date filed (Month, Day, Year)	M.D.	Shah A		. Hol.	Lywo	oa, M	บ 20	030				
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ORIGINAL

State of Maryland / Department of Health and Mental Hygiene U U 0 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month **Physician** Millenbur JR :20 P M homas 2006 March 10 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner If Under 1 Year If Under 24 Hrs. PICKERSGILL BALTIMORE NUrsing home 6. Sex 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** 101M 20 F Months Days Hours Min 705-10-8930 MD Yrs. Director march 14 1920 Usual Residence of Decedent 10a State 10b County 10c. City. Town or Location 10d. Inside City Limits 27 is marked other then "neturel, or items 23a or 28a-f show traumatic svsnt, the Medical Examinar must be notified at 1 Yes 2 No MD Director BALTIMORE owson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 615 hESTNUT AVE 2120 U.S.A Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1⊟Yes 2 □ No 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married U.5 Baltimore. Maryland 21215-0036 1□ Yes 3□No tf Yes, Give Year or Dates: Specify: Completed by → Widowed 4 Divorced ARMY LuhiTe 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 12 should be filed within 72 h and Mental Hygiene. 7 is marked other then "no Elementary/Secondary (0-12) College (1-4or 5+) 10 MANAGER GRAN GRP. NA 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Millenburg, SR homas Hubbard AURA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health and Important: if item 27 is n any injury or other traun Pennsylvania ave, STOCKSdAle 305.W ALAN Tauson MD 21204 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 3/15/06 → Burial 2 Cremation 3 Removal from State ' 4 ☐ Donation 5 ☐ Other (Specify) PARKWOOD cem 21. Sonature of Funeral Service Licensee PAUL STELLA FUNERAL Home, PA. 7527 har Roll Rs. Balto. MO 2 > Cella 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician 0 Mui stes /Medical Due lo (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner be executed the attending physician and ned for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Month Day signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Lear 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performed? 1 ☐ Yes 2 X No 24b. Were autopsy findings available prior to completion of cause of death? 2 No 1 Yes To the Hospitel or Attending Physicien: After this certification funeral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Jursing Home 5 Residence 6 Other (Specify) 1 TYes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of eath 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending within 24 hours after death.

To the Funeral Director: Af
completely filled in by the fu 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 🗌 Suicide 28e. Płace of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and axo Impleted cause of death (Item 23a) (Type, Print) and address of person who 6 Bin

Registrar

31. Date filed (Month, Day, Year)

MAR 1 5

32. Agistrar's Signature

December Answer Circle Modes   10 December Answer Circle Modes   10 December Answer Circle Answer				1 - For State Registrar	State of Ma	arylan		artment rtificate			ind M		giene Reg. No.	006	0788	36
## AGRICAL STATE AND PARTY LAND 18 COUNTY 10 C		Physici	an											Year	3. Time of De	eath .
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Privisician Michael Privis	75	Hygie ther t			)						r's Name	(First, Middle.	Maiden			
20s. Method of Disposition  Signature of Dense (Spearly)  21 Signature of Funeral Service Licensee  22s. Parts. Enter the disease, or complications that caused the death. Do not enter the mode of cyring, such as cardiac or respiratory arrest.  Physician Method of Disposition of Licensee  22s. Parts. Enter the disease, or complications that caused the death. Do not enter the mode of cyring, such as cardiac or respiratory arrest.  Physician Method of Disposition of Licensee  22s. Parts. Enter the disease, or complications that caused the death. Do not enter the mode of cyring, such as cardiac or respiratory arrest.  Approximate method of the cause o	ylan	Mental Mental arked o	To Be			Z						, ,		· · · · ·		
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Physician (Nectical Examiner)  Physician (Nectical Examiner)	200	nt of h		1 Burial 2 ☐ Cremation 3 ☐		C	emetery, cre	matory or ot	her place	-						
Physician (Nectical Examiner)  Physician (Nectical Examiner)	턡	artme ortant Injury			•	SAC										
23. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, internal Between Onset and Death Internal Between Conset and Death I	Ba	Depi Impo														
Physician (Medical Examiner Insulting in death)   Due to (or as a consequence of):   Due to (or as a consequence of):   Sequentially six conditions   Sequ		Mr. In		23a. Part1. Enter the disease, or com	plications that caused	the death								,	Approximate	00
Needical Examiner   Parameter	Physician		Immediate Cause (Final	One cause on each in		EUS										
Sequentially list conditions.    Sequentially list conditions.   Due to (or as a consequence of):		/Medical			Due to (or as											
Due to (or as a consequence of):    The teaching in death   Last   Continue	4	⊏xaminer		Sequentially list conditions,	b											
Due to (or as a consequence of):    The teaching in death   Last   Continue		ed isit	lne	if any, leading to immediate cause. Enter Underlying	Due to (or as	a consequ	uence of):									
FEDDOOD   10   10   10   10   10   10   10   1		and al-trar	xan	that initiated events	c. Due to (or as	a consequ	uence of):									
FEMALE:   23b. Was deededn pregnant in the past 12 rydnths?   1   Yes   2   No   9   Unknown   9   Unknown   9   Unknown   9   Unknown   1   Yes   2   No   3   Probably   4   Onknown   24a. Was an autopsy prior to completion of cause of death?   1   Yes   2   No   3   Probably   4   Onknown   1   Yes   2   No   3   Probably   4   Onknown   1   Yes   2   No   3   Probably   4   Onknown   1   Yes   2   No	200	sicien b burit			4											
O'C 'S PLOOD BY THE SECOND SEC	9	ificate g phy as the	edic		d											
O'C 'S PLOOD BY THE SECOND SEC	×	n cert ending use	M/u	23b. Was decedent pregnant				Testonio ne	- Contract				2	3d. Date of del	ivery	
The state of the cause of death?    1		0 0 0	sicia	1 ☐ Yes 2. Ø No	4☐Pregnant at									Month	Day Yea	נר
The state of the cause of death?    1	<u>Ф</u>	at the	Phy													
Company of the control of the cont		tuires the signer of signe	þ	Part II. Other significant conditions (	contributing to death bu	ut not resu	alting in the u	nderlying ca	iuse give	n in Part 1.						_
Company of the control of the cont	CO	s bee	olete											24b. Were au	itopsy findings ava	ailable
This part of the p	R	The ta	E O									perfo	rmed2	death?		se of
This part of the p	ital	ian: artifice ctor, p	0							26. Place	of Death					
Second Part   Second Part	× ×	hysic his ce il dire		1 ☐ Yes 2 ☐ No	1 🗆 Inpatie		<del></del>		A	Nur	sing Hon	ne 5□Resid	lence 6	□Other (Spe	cify)	
29a. Certifier (Check only one)  29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)	n c	ing P	lon:	Natural 5 ☐ Pending		Year)						8d. Describe h	ow injury	occurred		
29a. Certifier (Check only one)  29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)	isio	death death stor: , the f	icat	3 ☐ Suicide 6 ☐ Could not b	e Ope Diese of Init	Inc. At ho	ma form at			es 2 N		19f Location /6	Pront on	Alumba as G	and Davids At auto-	
29a. Certifier (Check only one)  29b. Signature and titte of certifier  29c. License number  29d. Certifier 29d. Certifier 29d. Date signed (Month, Day, Year)	Ď	after Direction by	ertif	4 Homicide determined	building, etc	. (Specify	nne, rann, si	eet, ractory,	, office		-			I Number or At	irai moute ivumbei	5
100 C		despita hours uneral	calc	29a. Certifier  (Check only 2 Medical Exa	nysician: To the best of	of my kno	wledge, deat	h occurred a	it the time	e, date and	place, a	and due to the o	cause(s)	and manner as	stated.	
100 C		thin 2. the f	0		and manner sta	ited.										
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  1 AN 14A2 KHE TERPAL 201 BACK RIVER NEUK ROAD #109 BALTIMARE, m.)  State Registrar  31. Date filed (Morth Day, Year)  12006560  MARCH 19, 2086  MARCH 19, 2086  MARCH 19, 2086  MARCH 19, 2086		P N TO		250. Signature and title of certifier	. 0			h	a s	~						
State Registrar  131. Date filed (Month Day Year)  132. Description of the state of death (Rem 23) (1996, Print)  134. Date filed (Month Day Year)  135. Date filed (Month Day Year)  136. Date filed (Month Day Year)  137. Date filed (Month Day Year)  138. Date filed (Month Day Year)  139. Date filed (Month Day Year)  130. Date filed (Month Day Year)  131. Date filed (Month Day Year)  132. Date filed (Month Day Year)	(	29		30 Name and add the Control	completed source of d	oath (tea	23a\ /T·	Print)	0000	>60		/	MATE	41 14	,2006	
State Registrar  31. Date filed (Mooth Day Year) WAR 1 5 2006  32. Pegistrar's Signature	a company	()		PAWILAS LIET	ERPAL 2T	O I C	3ACK	RIVER	Ne	FUL R	PAT	> #10	9 -	BALTIN	norti mi	>
				31. Date filed (Month Day, Year) MAR 1 5 2	32. Segistra	ar's Signa	ture	med ,								

			1 - For State Registrar	State of Man	yland / Depa		lealth and N	Mental Hygi	ene UU 6	07887
	Physic		1. Decedent's Name (First, Middle, Last)			Me	Zick	2. Date of Death	Day Year	3. Time of Death
	/Medi Examir		4a. Facility Name (If not institution, give st. Johns Hopkins-	7	س	4b. City, Town, or Baltiv	Location of Death		4c. County of Death	
	Funeral Director		5. Social Security Number 6. Sex 213-22-6873 XX	4 2 F	n yrs. last birthday) 9 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Nov. 12		place (State or Foreign intry) aryland
	hours after death with the Maryland tural', or Items 23a or 28a-f ehow at Examinar must be recitified at	Director	10a. State 10b. County  Maryland Baltimon		Edgemer					10d. Inside City Limits 1 ☐ Yes 2 🙀 No
	ath with the 23 or		10e. Street and Number  7425 Blevins Avenue			10f. Zip Code 21219			g. Citizen of What Cou United Sta	tes
920	72 hours after death with the Marylan natural', or items 23a or 28a-1 ehow area Extending the restilled at	by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  3 ☑ Widowed 4 □ Divorced	. Was Decedent Eve Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Was Decedent of H f Yes, specify Cuba ! ☐ Yes 2√2 No	ispanic Origin? (Sp n, Mexican, Puerto Specify:	pecify Yes or No- Rican, etc.)	14. Race - Amer Black, White Specify: Wh:	, etc.
21215-0036	s within 72 ho piene. r then "natur the Medical.	Completed	15. Decedent's Educa (Specify only highest grade Elementary/Secondary (0-12)	tion completed) College (1-4or 5+)	(Give	dent's Usual Occupi kind of work done o DO NOT use retired	ation during most of work )	king	6b. Kind of Business/Ir	ndustry
land 5	be filed tal Hygi of other event, I	To Be Co	10 years 17. Father's Name (First, Middle, Last) Evan Mezick		Stee	lworker	18. Mother's Nam	e (First, Middle, M	Steel aiden Sumame)	
, Maryland	and 2 should ealth and Mer m 27 is marke		19a. Informant's Name/Relationship (Type Gloria R. Sturmer	(Daughter	7425	Blevins	and Number or Rui Avenue	a <i>l R</i> oute <i>Number,</i> Baltimor	City or Town, State, Zi	,
Baltimore,	permit. Pages 1 an Department of Heal Important: If Itam 2 any Injury or other once.		20a. Method of Disposition  1	noval from State	Oak Lawn	cemetery Cemetery Name and Addres uda-Ruck	7 3/1 ss of Facility Funeral	Date $2^{1}$ $1/2006$ Home of I	Oc. Location - City or T Ealtimore, Dundalk, Ir	own, State Maryland
	Physician /Medical		23a. Part1. Enter the disease, or complica shock, or heart failure. List onty one Immediate Cause (Final disease or condition resulting in death)	tions that caused the cause on each line.  Due to (or as a co	death. Do not ent	922 Wise er the mode of dyin	Avenue g, such as cardiac	Dundalk, or respiratory arres	Maryland 2	Approximate Interval Between Onset and Death  4 days
,092	ate be executed with hysician and hysician and the burial-transit and	ilcal Examiner	Securitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  d.	Due to (or as a co	onsequence of):	oneun	nonia			4 days
P.O. Box 68	The law requires that the death certifica site has been signed by the atlending ph page 2 should be detached for use as th	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	. If yes, outcome of p 1 Live birth 2 L 4 Pregnant at tim 9 Unknown	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of deliv Month	ery Day Year
ords, P	equires that sen signed b	ted by P	Part II. Other significant conditions control  Alzheimer's Di	buting to death but n	ot resulting in the u	ndertying cause give	en in Part I.	23e. Did toba	acco use contribute to to	
al Rec	n: The law licate has b rr, page 2 st	Completed							ed? death? No 1 ☐ Yes	opsy findings available ompletion of cause of
ž	ysician is certii directo	To Be	25. Was case referred to medical examiner?  1 Yes 2 No Ho	pital: 1 X npatient	2 ☐ ER/Outpatien	t 3 DOA Othe	ac .	h Check only one	ice 6 Other (Speci	(v)
Division of Vital Records,	To the Hospital or Attending Physician: The law requir within 24 hours after death.  To the Funeral Director. After this certificate has been si completely filled in by the funeral director, page 2 should	Certification:	27. Manner of Teath  1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28a. Dote of Injury (Month, Day Ye				28d. Describe how	v injury occurred	
Div	To the Hospital or Attent within 24 hours after death to the Funeral Director: completely filled in by the		4 Homicide determined	28e. Place of Injury building, etc. (S ian: To the best of m	Specify)	Occurred at the lim	e, date and place,	City or Town,	uco(o) and manner as a	tatad
	the Ho iin 24 I the Fu ppletely	Medical	one)	r: On the basis of exa and manner stated	amination and/or inv	estigation, in my or	pinion, death occur	red at the time, dat	e and place, and due t	the cause(s)
	or with	2	29b. Signature and title of certifier			29c. License	5-000		d. Date signed (Month,	
5	Sta	te	30. Name and address of person who com Victoria HSiao, 31. Date filed (Month,-Pay, Year)	Johns - 32. Registrars	topkins t	Print) Pospital, 6	00 North	Wolfes	treet, Baltino	ZOO6 re, Maryland 2128
DHM	Registr MH 17 Rev 1/2	ar	MAR 1 5 200	5	15 A	we we				
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			1 - For State Registrar	State	of Marylar		artment of H Tificate of					) 6	07888
	Plane in i		1. Decedent's Name (First, Middle, La							Date of Deat Month	h Day	Year	3. Time of Death
	Physici /Medic		Richard Paul N	laffei						larch	09	2006	12:16 A <sup>M</sup>
	Examin	ner	4a. Facility Name (If not institution, giv	e street and no	umber)		4b. City, Town, o	or Location	of Death		4c. County		
			8344 Tapu Court 5. Social Security Number 6. S	av .	7. Age (In yrs.	last hirthday)	Perry If Under 1 Year		r 24 Hrs. To	Date of Birth	Ba	1timo	re ace (State or Foreign
	Funeral Director			M 2□F	52	Yrs.	Months Days	Hours	Min.	(Month, Day,	1953	Mary	try)
ס			Usual Residence of Decedent								1733	Much	-caria
ııylan	Mow The	_	10a. State 10b. County		10c. Ci	ity, Town or Lo	cation					10	Od. Inside City Limits
e Ma	8-17	Directo	Maryland Baltimo	re			Baltimo	re					1 ☐ Yes 2 No
with th	S or 2		10e. Street and Number	_			10f. Zip Code	01001	,	10	Og. Citizen of		try?
eath	10 23	eral	8344 Tapu Cours		cedent Ever in U	15 13 1	Was Decedent of H	21236		Yes or No-		S.A.	an Indian
fter d	튙칅	Funeral	1 Never Married 2 Marned	Armed F 1 ☐ Yes	orces? 2 X No	1	Was Decedent of H Yes, specify Cub			an, etc.)		ck, White,	etc.
Since	9 9	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, G Year or	ive		1□Yes 2XX No	Specify.	:		Specif	y: Wh	ite
72 hg	nage German	Completed	15. Decedent's E (Specify only highest gra		)	(Give	dent's Usual Occup kind of work done	durina mos	st of working		16b. Kind of B	usiness/Ind	lustry
within	then.	dm	Elementary/Secondary (0-12)	College	(1-4or 5+)		OONOTUSE retire	-/	onatan		Union	Local	#37
9 P	Hygie ther int, it	မ ငိ	12th Grade 17. Father's Name (First, Middle, Last	)		Heavy	Lyurpine		er's Name (Fi				
should be filed within 72 hours after death with the Maryland	Department of Health and Mental Hygiene. Important: or itame 23e or 28e-f show important: if item 27 is marked other than "natural", or itame 23e or 28e-f show any injury or other traumatic avent, the Medical Exeminar must be notified at once.	To B	Ernest Louis						e Eli				
2 sho	and is me	ľ	19a. Informant's Name/Relationship (		1		ng Address (Street					State, Zip	Code)
and	ealth m 27 her tr		Mrs. Mary Jeanne	Magger			· · · · · · · · · · · · · · · · · · ·	rt, B					
Pages 1	or of P		20a. Method of Disposition 1 X Burial 2 Cremation 3		State	cemetery, crer	sition (Name of natory or other pla	1	Date		20c. Location		
ے 2	rtant		4 ☐ Donation 5 ☐ Other (Specification 21. Signature of Funeral Service Licer		St		h Ch. Ce . Name and Addre		3/13/0		altimo	re, M	aryland
Dermit.	Depa Impo any it		Buanal	el le	<b>&gt;</b>		05 Belai						۵
			23a, Part1. Enter the disease, or com shock, or heart failure. List only	plications that	caused the dea each line.						<del></del>		Approximate Interval Between
P	nysician		Immediate Cause (Final disease or condition	· Cost	diac	ton	oppose						Onset and Death
	Medical xaminer		resulting in death)	Due to	(or as a consec	quence of):	ponade			-			
	Ad. III.	7.	Sequentially list conditions,	b. hea	o (or as a consec	Co To	lium						
hetr	1 Insit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	F-, .			rtico	1.20	or to	20			
exec	an and rial-tra	Exa	resulting in death) Last	C. Due to	or as a consec	quence of):	11100	C1 23	ecne	111			
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	ding pl	Med	IF FEMALE:	00-14		E.J.							
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the d	y the	Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9☐ Unki		Jean 5	Other (specify) _						
s that	n signed by the a Id be detached f	by Pr	Part II. Other significant conditions	ontributing to	death but not res	sulting in the u	nderlying cause giv	ven in Part	ı.	23e. Did tob	acco use con	tribute to th	e cause of death?
eduire	been sig should b	ed t								1 ☐ Ye	s 2□No	3 🗌 Prob	ably 4 Unknown
la v E	as be 2 sho	Completed								24a. Was an	24b.	Were autop	osy findings available
The	ate h page	Con								perform	ned?	death?	2 No
cian	ector,	Be	25. Was case referred to medical examiner?	Hospital:			104		e of Death (Co	heck only one	9)		at scene
. g	this rail dir	. To	14 Yes 2 No 27. Manner of Death	28a. Date		ER/Outpatien 28b. Time of	, 90 DOX		ursing Home		nce 6 Oth	ner (Specify	, at seeme
diag	th. : After	Certification:	1 Natural 5 Pending 2 Accident investigatio	(Mo	nth, Day Year)	Injury	Wo	rk?` ]Yes 2□		. 26301106110	w injury occur	100	
Atts	ector by the	Iffice	3 Suicide 6 Could not b 4 Homicide determined	289. Plac	e of Injury - At h	ome, farm, str	eet, factory, office		28f.			oer or Rura	Route Number,
2 👼	rs afte ral Dir led in	Cer		Duik	Jing, etc. (Speci	·y/				City or Town	, 5/4/6/		
To the Hospital or Attending Physician: The law requires that the death certificate be executed	within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medical	29a. Certifier 1 Certifying Pt (Check only 2 Medical Examone)	niner: On the	e best of my kno basis of examina nner stated.	owledge, death ation and/or in	occurred at the ti vestigation, in my o	me, date ar opinion, dea	nd place, and ath occurred a	due to the ca at the time, da	use(s) and mate and place,	anner as sta and due to	ated. the cause(s)
To the	within To tha	Me	29b. Signature and title of certifier		~		29c. Licens	se number		29	9d. Date signe	d (Month, L	Day, Year)
)	-, <b>u</b>		Material.	2 cm.	1-120	02.	0.	.C.M.I	Ε.	1	March C	9, 20	006
	$\sigma_{i}$		30. Name and address of person who	completed cau		%							
	1		PATRICIA AD	nica-	KILLY	111ص	Penn Sti	reet,	Baltin	nore, 1	Marylar	d 212	:01
	Sta Registr		31. Date filed, Month, Day Year MAR 1 5 2006	Lines.	Registrar's Sign	Coest	9						

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene.

			1 - For State Registrar	State of Maryland / D	epartment of H Certificate of L		Mental Hygie	ZUUb	07889
	Physici /Medic		1. Decedent's Name (First, Middle, Last	de Martin				Day Year Q 2006	3. Time of Death 12:35 PM
	Examir Funeral Director		4a. Facility Name (If not institution, give Casey House 5. Social Security Number 6. S 446-44-1145		Rockvi	Location of Death  Ne If Under 24 Hrs. Hours Min.	l l		olace (State or Foreign
	ס	tor	Usual Residence of Decedent  10a. State  10b. County  Mb. Montgo	nery Rock	8		1 1 1 1		1 ☐ Yes 2 No
	th with the 23s or 28s	Funeral Director	10e. Street and Number 4407 Morgal S	treet	10f. Zip Code 2085	3	10g.	Citizen of What Cou	ntry?
036	within 72 hours after death with the Maryland ene. then "natural", or Items 23e or 28e-f ehow ta Mudical Examiner must be notified at	þ	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	13. Was Decedent of Hi If Yes, specify Cubar 1  Yes 2 No	spanic Origin? (Sp n, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White, Specify: Wh	ean Indian, etc.
21215-0036	within 72 ho jiene. r then "natur r in Medical	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)	ucation de completed)  College (1-4or 5+)	Decedent's Usual Occupa Give kind of work done d life. DO NOT use retired,	luring most of work )	ring	esearch	
Maryland ?	should be filed nd Mental Hygid marked other umatic event, II	To Be C	17. Father's Name (First, Middle, Last) George W. M  19a. Informant's Name/Relationship (i	artin		18. Mother's Name Betty 1	e (First, Middle, Maid	den Sumame) CKleton	
altimore, Ma	es 1 and 2 of Health a f Item 27 is r other train		Diane Martin (20a. Method of Disposition  1 Burial 2 Geremation 3 4 Donation 5 Other (Specific	Nife 440 Removal from State 20b. Place of competery	Mailing Address (Street a	5+. Roc	Date 200	ND 2085 Location - City or To	3 own, State
Baltir	permit. Pag Department Important: I any Injury o		21. Signature of Funeral Service Licen		22. Name and Addres	s of Picility Ra	pp Funera	l+Crema	tion Services
	Physician /Medical Examiner	er	shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate	b.  Due to (or as a consequence of	t):	g, such as cardiac	or respiratory arrest,		Approximate Interval Between Onset and Death
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P.O. Box 6	that the death certificated by the ettending produced for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)			23d. Date of delive Month	ery Day Year
ords, P	w requires that been signed t should be det	Ď	Part II. Other significant conditions of	ontributing to death but not resulting in	the underlying cause give	n in Part I.	23e. Did tobacc	co use contribute to the	ne cause ol death? ably 4  Unknown
of Vital Records,	an: The law r tificete has be tor, page 2 sh	e Completed	25. Was case referred to medical				24a. Was an autopsy performed:	prior to co	psy findings available inpletion of cause of 2 No
Ξ	Physician: rthis certifice ral director, p	To Be	examiner?	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outp	patient 3 DOA Othe	r	n <i>(Check only one)</i> me 5 ☐ Residence	6 Other (Specific	Hospice
	ding After fune		27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day Year) 28b. Ti	me of 28c. Injury Work		28d. Describe how in		Morro
Division	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the fune	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	1			28f. Location (Street City or Town, St	t and Number or Rura tate)	l Route Number,
	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	edicai	29a. Certifier Certifying Phrophis (Check only one)	vsician: To the best of my knowledge, iner: On the basis of examination and and manner stated.	death occurred at the time for investigation, in my op	e, date and place, inion, death occurr	and due to the cause red at the time, date a	e(s) and manner as si and place, and due to	ated. the cause(s)
	To th To th comp	W	29b. Signature and title of certifier	^^^	29c. License		29d. I	Date signed (Month,	Day, Year)
•	(10		30. Name and address of person who of	completed cause of death (Item 23a) (T	D356			10-06	
	7		Joseph Kaplan 60	101 Muncastez M	ill Rockvil	lle, MD	20855		
	Sta Registr		31. Date filed (Month, Day, Year)  MAR 1 5 7	32. Registrar's Signature	Coule				

June 06-01 crn	Harlow M 782	ſu1	len Please Unpend item# 23a, 27,	Type or Prir	n <b>t in B</b> l 3/21/06	ack In	delible Ink	. Ensure	All Copies	Are Le	gible.	
LII			For State Registrar	State of Ma	aryland		artment of F <i>rtificate of</i>		Mental Hy	giene Reg. No.	06	07890
	Physic	ian	1. Decedent's Name (First, Middle, Las June H. Mull	•					2. Date of Do Month	aath Day	Year	3. Time of Death
	/Medi Exami	ical	4a. Facility Name (If not institution, give				4b. City, Town, o	or Location of Dea	March	12'	2006 nty of Dea	
		_	832 Arncliffe Ros	ad			Essex					imore
97	Funeral Director			9X 7. Aga □ M 2 1 F 7. Aga	в (In yrs. Ia. 74	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min		v. Year)	9. Bird Co	thplace (State or Foreigr Duntry) Carolina
73	yland		Usual Residence of Decedent  10a. State 10b. County		10c. City,	Town or Lo	cation				-	10d. Inside City Limits
	Ba-f s	ector	Maryland Baltimo	re		Essex						1 ☐ Yes 2 ☐ No
	ath with the Marylar s 23a or 28a-f show sast by nutified at	Dir	10e. Street and Number 832 Arncliffe Ro	ad			10f. Zip Code	21221		10g. Citizen o	of What Co	•
90	er de	by Funeral Director	11. Marital Status  1 Never Married 2 Married  3 🛣 Widowed 4 Divorced	12. Was Decedent I Armed Forces? 1 ☐ Yes 2 ☒ N If Yes, Give Year or Dates:	Ever in U.S	-	Vas Decedent of h f Yes, specify Cub	dispanic Origin? (S an, Mexican, Puer Specify:	Specify Yes or No to Rican, etc.)	)- 14. R	ace - Ame lack, Whit	erican Indian,
5	72 hours natural',		15. Decedent's Ed	ucation		16a. Dece	lent's Usual Occup	pation	adala a	16b. Kind of	Business	(Industry
2000 310 to business of 515 0005	within 7	Completed	Elementary/Secondary (0-12)	College (1-4or 5	+)		oo NOT use retire	during most of wo d)	rking	Baltin		
<u>ç</u>	filed of Hygie other it	Be Co	12th Grade  17. Father's Name (First, Middle, Last)			3000	u worke	,	me (First, Middle	Social Maiden Suma		vices
Š	yidi buld be Menta Menta arked	To B	Norman Beecher I	Brantley				Luda	Surname	Unknou	in)	
Š	Mar d 2 sho th and 7 is m trsum		19a. Informant's Name/Relationship (7 Cowrtney Johnson		26+1+			and Number or Re				
\$	s 1 and f Heali		20a. Method of Disposition		20b. Pla	ce of Dispo	sition (Name of natory or other pla		Date	20c. Location	212. n - City or	
ğ	Page Page ment o ant: if ury or		1 ☐ Burial 2 🕱 Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify			riew (	Crematory	3/14				Maryland
9	permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: if itsm 27 is marked other than insturany injury or other treumstic svent, the Madical ADGE.		21. Signature of Funeral Service Licen  Buun G. W.					iss of Facility Sci Ir Rd., B				nes
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0	tuires that n signed build be deta		Part II. Other significant conditions of	entributing to death bu	ut not result	ing in the ur	iderlying cause giv	en in Part I.		obacco use co Yes 2 □ No		the cause of death?
Olivision of Wital Bonden	The law requir	Completed	N .						24a. Was auto perfo	osy ermed?	death?	topsy findings available completion of cause of
-	vician: The certificate rector, pag	BeC	25. Was case referred to medical examiner?					26. Place of Dea	1 X Yes	2□ No ne)	1 Yes	2□ No
Ę	Physic this or	ပ္	examiner? 1	Hospitaf: 1 ☐ fnpatie		VOutpatien		4 🗆 Nursing F	fome 5 Resi			at scene
5	Mtending F death. ctor: After y the funer	ertification:	1 Naturaf 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injur (Month, Day	Year)	fnjury	28c. Injur Wor M 1	yai k? Yes 2∐No	28d. Describe	now injury occu	rued	
	tal or Att s after de al Direct ed in by t	Certific	3 ☐ Surcide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of fnju building, etc	ry - At hom :. (Specify)	e, farm, str	et, factory, office		28f. Location ( City or To	Street and Nun vn, State)	nber or Ru	ral Route Number,
	To the Hospital or Attenwithin 24 hours after deall To the Funeral Director: completely filled in by the	edical (	29a. Certifier 1 ☐ Certifying Phy (Check only one) 2 【XMedical Exam	rsician: To the best of iner: On the basis of and manner sta	examinatio	edge, death n and/or inv	occurred at the tir estigation, in my o	ne, date and place pinion, death occu	e, and due to the urred at the time,	cause(s) and n date and place	nanner as e, and due	stated. to the cause(s)
	To the within 2 To the comple	Me	29b. Signature and title of certifier				29c. Licens			29d. Date sign		
			30. Name and address of berson who d		ath (Item 2	За) (Туре,		).C.M.E.		March 1	13, 2	2006
			tamele E. Sou				Penn Str	eet, Bal	timore,	Maryla	nd 21	.201
	Sta Registi		31. Date filed (Month, Day, Year) MAR 1 5 2006	32. Registra	ır's Signatui	Sac s						

State of Maryland / Department of Health and Mental Hygiene State Amend Item#7 per FH G853 3/16/96/16@ Late of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 3 Day **Physician** Elsie M. Mobley 2006 8:57 a.M 13 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 8601 Lisa Ct Randallstown Balto If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Qay, Year) 8-30-1937 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 ☐ F 216-32-3689 67 68 Yrs. Director Ga Usual Residence of Decedent the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 28e-1 ehow 1 XYes 2 No Directo Balto Randallstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? rai', or iteme 23a or Examiner must be 8601 Lisa Ct 21133 USA Pages 1 and 2 should be filled within 72 hours after death nent of Health and Mental Hygiene.
ant: If Item 27 is marked other than "natural", or fleme 23 art ury or other traumatic event, its Medical Examinations. by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 24☐ No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Marned Baltimore, Maryland 21215-0036 1 ☐ Yes 🛣 No Specify: Black 3 Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Baltimore City Public Elementary/Secondary (0-12) College (1-4or 5+) 12th grade years Teacher Schools unk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Georgia Brandenburg ٩ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Stephanie Roberts - Daughter 8601 Lisa Ct Randallstown, Md 21133 20a. Method of Disposition
1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Page Department of Important: If eny injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Garrison Forest Vet 3-17-2006 Owings Mills, Md 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March F/H West 4300 Wabash Avenue Balto, Md 21215 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) rsicien and burial-transit The law requires that the death certificate be executed Exam Due to (or as a consequence of) Records, P.O. Box 68760, physicien Physician/Medical use as the ettending I IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Month Year Day 4 Pregnant at time of death 5 ☐ Other (specify) signed by the e 9 Unknown 9 Unknow Part to Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗆 Yes 2 No 3 Probably 4 Unknown peeu 24b. Were autopsy findings available prior to completion of cause of death? certificate hes b lirector, page 2 s 24a. Was an Was an autopsy performed?
Yes 2 X No 1 Yes 1 Tyes Division of Vital To the Hospital or Attending Physicien: within 24 hours efter death.

To the Funerel Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death Check only one Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 \( \sum \) Nursing Home 1 ☐ Yes 2 No Certification: To 5 Tesidence 6 Other (Specify) 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of D. ath 28c. Injury at Work? 28d. escribe how injury occurred 1 Natural
2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a Cartifian 1 Certifying Physicians To the best of my knowledge, death secured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifiq 29c. License number 27 30. Name and address of person why completed cause of death (Item 23a) (Type, Print) De Baltima 6 31. Date filed (Month, Day, Year) 32. Régistrar's Signature State 5 MAR 1 2006 Registrar

State of Maryland / Department of Health and Mental Hygiene 🛭 🗎 🗧 07892 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Month 3 **Physician** 12 2006 2:30 P Heraclia /Medical Torres Molina 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Balto N/A 1415 W. Baltimore Street If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 □ M 2 🕅 F 91 Yrs. Director 582-09-6747 D Puerto Rico Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a State 10b County 10d. Inside City Limits r 28a-f ahow MdN/A Balto M☐Yes 2☐No Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with ral', or Itams 23e or Examiner must be r 1415 W. Baltimore Street 21223 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 No Specify: 3 ☐Widowed 4 ☐ Divorced Year or Dates: 'natural' r than "natur the Medical I 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Housewife Home NA NA other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pedro Torres Mercedes Molina 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Heelth 1415 W. Baltimore Street Baltimore, Md 21223 Itam 2 Felipe R. Torres - Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Depertment of Himportant: If Ita any Injury or of once. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 3/18/2006 4 ☐ Donation 5 ☐ Other (Specify) Aiecibo Cemetery Aiecibo, Puerto Rico 21. Signature of Fun and S rvice Licensee 22. Name and Address of Facility March F/H West 4300 Wabash Avenue Balto, Md 21215 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician G disease or condition resulting in death) /Medical Due to for as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine To the Hospitel or Attending Physician: The law requires that the death certificate be executed attending physicien and for use as the burial-transit resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Dav 4□Pregnant at time of death 5 Other (specify) ned by the a detached f 9 Unknown 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, s been signer δ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? certificate has birector, page 2 s autopsy 2□ No 1□ Yes 2 No 1 Yes director 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 2 No Certification: To 1 TYes 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) After thi funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation death by the f 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by t within 24 hours after d To the Funeral Direct completely filled in by 4 Homicide 29a. Certifier (Sectifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stayled. (Check only one) 29b. Signature and the of contifie 29c. License number 29d. Date signed (Month, Day, Year, A of death (Item 23a) (Type, Print) 30. Name and address of person cause 31. Date filed (Month, Bay, Year) Registrar's Signature 32. State Registra

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21. Signaturé bit Fundral Service Libensee  22. Part Entre the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrasi, immediate Cause (Final shock, or heart failure. List only one cause on each time, each or enter the mode of dying, such as cardiac or respiratory arrasi, immediate Cause (Final rise and Death of Cause (Final rise and Death of Cause). The final rise of Death of Cause (Final rise and Death of Cause) are considered on each fine.  22. Lung Cancer  3. Due to (or as a consequence of):  3. Due to (or as a consequence of):  4. Due to (or as a consequence of):  5. Due to (or as a consequence of):  6. Due to (or as a consequence of):  7. Due to (or as a consequence of):  8. Due to (or as a consequence of):  8. Due to (or as a consequence of):  9. Due to (or as a consequence of):  9. Due to (or as a consequence of):  1. Due to (or as a consequence of):  1. Due to (or as a consequence of):  1. Due to (or as a consequence of):  2			ionioval nom State				3/17/	2006	Odei	nton. Ma	arvland
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29a. Certifier   Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   Certifier   Certifier   Death of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   29b. Signature and title of certifier   Death of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   29b. Signature and title of certifier   Death of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   29b. Signature and title of certifier   Death of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   29b. Signature and title of certifier   Death occurred at the time, date and place, and due to the cause(s) and manner as stated.   29b. Signature and title of certifier   Death occurred at the time, date and place, and due to the cause(s) and manner as stated.   29b. Signature and title of certifier   Death occurred at the time, date and place, and due to the cause(s) and manner as stated.   29b. Signature and title of certifier   Death occurred at the time, date and place, and due to the cause(s) and manner as stated.   29b. Signature and title of certifier   Death occurred at the time, date and place, and due to the cause(s) and manner as stated.   29b. Signature and title of certifier   Death occurred at the time, date and place, and due to the cause(s) and manner as tated.	0	1 ZA¥atural 5 ☐ Pending	(Month, Day Year)					8d. Describe	how injur	y occurred	
29a. Certifier (Chick builty one) 29b. Signature and title of certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Martin Weltz, M.D. 7525 Greenway Center Drive Greenbelt, Maryland 20770 31. Date filed (Month, Day, Year) 32. Registrar's Signature	cat		<u> </u>								
29a. Certifier (Circle Control one) 29b. Signature and title of certifier 29b. Signature and dadress of person who completed cause of death (Item 23a) (Type, Print) Martin Weltz, M.D. 7525 Greenway Center Drive Greenbelt, Maryland 20770 31. Date filed (Month, Day, Year) 32 Registrar's Signature	Ė	dotomniand	building, etc. (Specify)	ne, farm, stre	et, factory, of	fice	2	281. Location ( City or To	Street an wn, State,	d Number or Ru. )	ral Route Number,
29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Martin Weltz, M.D. 7525 Greenway Center Drive Greenbelt, Maryland 20770  31. Date filed (Month, Day, Year)  32 Registrar's Signature		20. 0. 111 . XX									
D23743 March 13, 2006  30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Martin Weltz, M.D. 7525 Greenway Center Drive Greenbelt, Maryland 20770  31. Date filed (Month, Day, Year)  32. Registrar's Signature	lica	Condex only 2 Medical examin	ier. On the basis of examinati	riedge, death on and/or inv	occurred at the estigation, in it	ne time, date ar my opinion, dea	nd place, a ath occurre	nd due to the	cause(s) date and	and manner as place, and due	stated. to the cause(s)
D23743 March 13, 2006  30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Martin Weltz, M.D. 7525 Greenway Center Drive Greenbelt, Maryland 20770  31. Date filed (Month, Day, Year)  32. Registrar's Signature	Med	3/10/	and manner stated.								
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Martin Weltz, M.D. 7525 Greenway Center Drive Greenbelt, Maryland 20770  31. Date filed (Month, Day, Year)  32. Registrar's Signature	1		1100-1-		29C. LI	Jense number			∠⊌d. Dat	⊌ signed (Month	i, Day, Year)
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DHMH 17 Rev 1/2001

			For State Registrar		State of	Maryland /		artmen rtificate					giene Reg. No.	006	07894
	Physici	an	1. Decedent's Name	_								2. Date of De		Year	3. Time of Death
	/Medic		GEORGE		MARTIN							MARCH		2006	
	Examir	er	4 .		give street and numb					Location of	of Death		,	County of Dea	
			5. Social Security Nui		GENDRAL 7	Age (In yrs. last			1 Year		24 Hrs.	8. Date of Bir			
	Funeral Director		090-24-74	70	6. Şex 1X M 2□ F	75	Yrs.	Months	Days	Hours	Min.	(Month, Da	y, Year)	0	rthplace (State or Foreign country)
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	nylan how	_	10a. State	10b. County		10c. City, To	own or Lo	cation							10d. Inside City Limits
	Be-f e	Director	Maryland		Howard				C	olumbia	a				1 ☐ Yes 2 No
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re,	s 1 ar		20a. Method of Dispo	sition		20b. Place	of Dispo	sition (Nam	ne of ther place	e)	Da	ite	20c. Loc	ation - City or	r Town, State
Ē	Page nent c		1⊿NBurial 2 ⊔ `4 □Donaytion 5		3 □Removat from State	110		ia Mem		!	03/1	4/2006		Clarksvil	le, Maryland
Baltimore, Maryland 21215-0036	permit. Pages: Department of the Importent: If ite any injury or of once.		21. Six ature of Fund	eryservice L	icense		22	. Name an			-	D 4			
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г			shock, or heart	failure. List of	complications that cou only one cause on eac	sed the death. D h line.	o not ent	er the mode	e of dying	, such as	cardiac or	respiratory a	rrest,		Approximate Interval Between Onset and Death
	Physician		Immediate Cause (F disease or condition resulting in death)	inal	-a. Aw	TE PS	PIR	FTM	4 1	ALL	URE				14 DAYS
	/Medical Examiner		rooming in double		Due to (or	as a consequence	ce of):								3 WEEKS
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<u>α</u>	The law requires that the death certifi ate has been signed by the attending I page 2 should be detached for use as	y Ph	Part II. Other signific	ant condition	ns contributing to deat	h but not resulting	g in the ur	nderlying ca	ause give	n in Part I.		23e. Did to	obacco us	e contribute t	o the cause of death?
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	To the Hospitel or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifical completely illied in by the funeral director.		29a. Certifier 1	Certifying	Physician: To the b	est of my knowled	lge, death	occurred a	at the time	e, date and	d place, ar	d due to the	cause(s) a	and manner a	s stated.
	n 24 I he Fu pletely	Medical	(Check only 2 one)	Medical E	xaminer: On the basi and manne	s of examination.	and/or inv	estigation,	in my op	inion, deat	th occurred	at the time,	date and	olace, and du	e to the cause(s)
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	32		00. Name and address		who completed cause	of death (Item 23a	a) (Type,	Print)	*TUX	ONT	PKW	y wi	umbi	4 mo	21544
	Sta		31. Date filed (Month			istrar's Signature		9							
	Registr	वा	MAR 1	15200	5 Barre	D. C									

DHMH 17 Rev 1/2001

CPM 06-01612 Timothy Martin

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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eral ctor	5	. Social Security Number 6. S 572.92.5147	ex M 2□F	Age (In yrs.	last birthday) 52 Yrs.	If Under Months		If Under Hours	24 Hrs. 8 Min.	B. Date of Birt (Month, Day	Year)	9. Birti Co	hplace (State ountry)	or Foreig
		Jsual Residence of Decedent				1 1			'N	lovember	15, 19	53	Michiga	n
Ħ .		0a. State 10b. County		10c. City	y, Town or Lo	ocation							10d. Inside C	' /
notified at			loward					llicott C	ity				1 🗌 Yes	21211
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by Funeral Director		1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Force 1 Tyes 2 If Yes, Give 7 Year or Date	No		If Yes, spec	~ /	n, Mexicar Specify:	, Puerto Ri	ican, etc.)		Black, White Specify:	e, etc. White	
Completed		15. Decedent's Ed	ducation		16a. Dece	dent's Usua	al Occupa	ition			16b. Kind	d of Business/		
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Nicholas, Jr. Herman L. :20 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. Gity, Town, or Logation of Death **Examiner** saltimore 5. Social Security Number 9. Birthplace (State or Foreign **Funeral** Days 1**X** M 2□ F Hours Alabama 421-38-9669 71 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits traumatic avent, the Medical Examiner must be notified at 1 ☐ Yes 2 No Maryland Directo Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of Whal Country? 517 Crisfield Road 21220 U.S.A. Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No δ Specity: White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12th Grade Machinist Lucent Technology 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Herman L. Nicholas. Sr. Eva Poole 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2: Department of Health ar important: If Itam 27 is any injury or other traugues. Katherine F. Nicholas 517 Crisfield Road, Baltimore, MD 21220 (wife) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 & Other (Specify) Entombment Holly Hill Mausoleum 3/14/2006 Baltimore, Maryland 22. Name and Address of Facility Schimunek Funeral Homes 21. Signature of Fineral Service Licensee 9705 Belair Rd., Baltimore, MD 21236 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician nolariaio /Medical Due to (or as a consequence of): Examiner Sequentially list for alto-if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): or Attending Physicien: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 12 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has tirector, page 2 s 2 No 1 ☐ Yes 25. Was case referred to medical examiner? To Be 26. Place of Death (Check only one) Other 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 1 DNatural 28a. Dale of Injury (Month, Day Year) 28b. Time of Injury Certification: 28d. Describe how injury occurred 5 Pending investigation death. 1 ☐ Yes 2 ☐ No I Diractor: A 2 Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after of To the Funeral Direct completely filled in by filled in by 4 Thomicide o the Hospitel 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0551x 3/11/06

Registrar

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State

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HERMAN

Drive Baltimare Md

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

5 2006

32. Registrar's Signature

31. Date filed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 2. Date of Death Decedent's Name (First, Middle, Last) Day Month Year 1349 M **Physician** 2006 O Rowke 12 03 /Medical 4c. County of Death 4b City Town or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner NIA Colley R Adams Sok Traun Baltiner Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 M 2□ F Yrs. 42 Director 064.50.2171 New York October 11, 1963 Usual Residence of Decedent filed within 72 hours after deeth with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County or 28a-f show the Medical Examiner must be notified at 1 Yes 2 No **Funeral Director** Ellicott City Maryland Howard 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21043 USA 3155 West Springs Drive; Apt. B or items 23a 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 MNo If Yes, Give Year or Dates: 14. Race - American Indian, 11. Marital Status Btack, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify White Be Completed by 3 ☐ Widowed 4 Divorced "natural", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Carpet company Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Manager 2 college .. Pages 1 and 2 should be filed w tment of Heelth and Mental Hygier tant: if Itam 27 is marked other ti jury or othar traumatic event, ID. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Thomas J. O'Rourke Marianne Martin 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 113 Babcock Road Horseheads, NY 14845 Ms. Marianne O'Rourke Mother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 Decremation 3 ☐ Removal fr. m State 4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department o important: if eny injury or once. 03/15/2006 Baltimore, MD Bayview Crematory 22. Name and Address of Facility Agnatus of Fundal Service Licenses Slack Funeral Home, P.A. 110053 S 3971 Old Columbia Pike Ellicott City, MD 21043 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death mmediate Cause (Final disease or condition resulting in death) Supsis -Streptococcus **Physician** /Medical Due to (or as a consequence of). Examiner Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner and Il-transit The law requires that the death certificate be executed Due to (or as a consequence of) attending physicien a for use as the burial-Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Year Month Dav in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No detached Records, P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Tes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a Wasan has autopsy performed? 2 🗆 No 1 Yes 2□No Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 No 2 28a. Date of Injury (Month, Day Year) 28c. 28d. Describe how injury occurred 28b. Time of 27 Manner of Death Injury at Work? Certification: Injury 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide t 📡 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 16535 3/12/2006 30. Name and address of per suratio completed cause of death (Item 23a) (Type, Print) 22 S. Grew St Felix Lui 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 2006 DHMH 17 Rev 1/2001

			1 - For State Registrar	Olate of W	aryland		rtificate o	f Death	vicinaring	Reg. No.	UU b	0/090			
	Dhusia		1. Decedent's Name (First, Middle, La	st)					2. Date of D	eath Day	Year	3. Time of Death			
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1	Examir		4a. Facility Name (If not institution, give				4b. City, Town	, or Location of Death	)	4c. 0	County of Death				
			JOHNS HOPKINS BA	WIEW MENCA	L CENT	ER	BAL	TIMORE			N/A_				
П	Funeral		5. Social Security Number 6. S 156 – 28 – 5904		ge (In yrs. las.	t birthday) Yrs.	If Under 1 Year Months Day		8. Date of Bi (Month, D	ay, Ye <i>ar)</i>		ace (State or Foreign ry)			
	Director		Usual Residence of Decedent		68	113.			Jan.3	1, 19	38 New	Jersey			
	/land		10a. State 10b. County		10c. City, 7	Town or Lo	cation				10	d. Inside City Limits			
	Mary	ţ	Md. Carol	ine		Dent	on					1 ☐ Yes 2 🛣 No			
	h the	Director	10e. Street and Number				10f. Zip Code	)		10g. Citiz	en of What Count	ry?			
	th wit	교	25860 Garey Rd.				Г	enton			USA				
	r dea	ner	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S.	13.		f Hispanic Origin? (Suban, Mexican, Puerto	pecify Yes or No	p- 1-	4. Race - America				
21215-0036	be filed within 72 hours after death with the Maryland tal Hygiene. d other than "natural", or Items 23e or 28e-f show event, the Madical Examiner must be notified at	by Funeral	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 Tyes 2 If Yes, Give Year or Dates:		7	1 ☐ Yes 2 🛣 N		o rilicari, etc.)	i i	Black, White, e Specify: Whi				
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Baitimore,	arth orts Inju	1 7	21. Signature Funer Service Licer		Meci	22	. Name and Add	Inc.   3/14 Iress of Facility Sta	+/00 ellings	Funo	imore, M	aryland			
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	To the Hospital or Attending Physician: white 24 hours state death. To the Funeral Director: Attenthis certific completely filled in by the funeral director,	Medical	one)	niner: On the basis of and manner sta	examination.	and/or inv	estigation, in my	opinion, death occur	red at the time,	date and p	lace, and due to t	he cause(s)			
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State Registrar

4940 EASTERN AVENUE BALTIMORE MD 24224 32 Registrar's Signature

		1 - For State Registrar		State	of Maryla		artmer rtificat		lealth and N Death	Mental Hy	giene. Reg. No.	006	07899
Physi	cian	Decedent's Nam	e (First, Middle							2. Date of Do		Year	3. Time of Death
/Med		Darius		В.		Peni	ningto			March	13, 2	2006	10:30 A
Exam	iner	4a. Facility Name ( Stella M	aris Ho	spice			7oT	wson	Location of Death			County of Deat	
Funera Directo		5. Social Security N 224–26–3 Usual Residence of	059	6. Sex 1	7. Age (In yr	s. last birthday,	Months	Days	If Under 24 Hrs. Hours Min.	8. Date of Bi (Month, Di July 3	th ay, Year) 1924	9. Birt Vir	hplace (State or Fore untry) ginia
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3a or 28	Funeral Director	10e. Street and Nu 8161 Mid		Road			10f. Zip	Code 2122	22		10g. Citize	en of What Co	untry?
if Health and Mental Hygiene. Item 27 is marked other than "natural" or Items 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at	by Funer	11. Marital Status  1 Never Man  3 Widowed		Armed F	2 □ No iive	U.S. 13.	Was Dece If Yes, spe		ispanic Origin? (Sp n, Mexican, Puerto Specify:	pecify Yes or No Rican, etc.)		4. Race - Ame Black, White Specify: Wh	
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within 2 To the complete	Me	29b. Signature and	title of certifier	)				. License			29d. Date :	signed (Month	, Day, Year)
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q		30. Name and addr		•	se of death (Ite	em 23a) (Type,			,,,,			11 5/0	

State of Maryland / Department of Health and Mental Hygiene [] [] 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Month Christopher A. Pfeifer 11:25a4 March 1 1 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore 349 Dark Head Road Middle River If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Oct. 10, 1921 Birthplace (State or Foreign PA **Funeral** Months 1 XM 2 ☐ F 213-18-3945 84 Yrs Director Usual Residence of Decedent with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Item 27 is marked other than "natural", or Items 23s or 28s-f show other traumatic event, the Mudical Examinar must be notified at MD Baltimore Director Middle River 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 349 Dark Head Road 21220 USA Funeral death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian. Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. Int: If Item 27 Is marked other then "natural", or Ite Black, White, etc. M Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: δ Specify:White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) MArtins Shop Supervisor 2vrs 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Christopher Pfeifer Margaret Hughes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Darlene C. Pfeifer /wife 349 Dark Head Road Baltimore MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of H Importent: If Ite any injury or of once. 1 Burial 2 Cremation 3 Removal from State Baltimore MD SacredHeartofJesus 3/15/06 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility ConnellyFuneralHomeofEssex 21. Signature of Funeral Service Licenses 300 Mace Ave. Baltimore MD 23a. Part1. Enter the disease, or comshock, or heart failure. List only applications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Cordiovepivator **Physician** /Medical Due to (or as a consequence of): Examiner Hepatoma Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner physicien and s the burial-transit certificate be executed Metastal Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Physician/Medical signed by the ettending d be detached for use as 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform d? 1□ Yes or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home P 1 Inpatient ome 5 Residence 6 Other (Specify)
28d. Describe how injury occurred 2 ER/Outpatient 3□ DOA this completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 28b. Time of After 1 Natural 2 Accident 5 Pending investigation death. 1 ☐ Yes 2 ☐ No s after death 3 🗀 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospitel o within 24 hours aff To the Funerel Di Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a Certifier 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 56466 13 2006 atal 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BLUD 49246 SWATI AMPBELL WHITE 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

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Registrar

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		1 - For State Registrar	State of Maryl		artment ertificate			nd Me		ene g. No.		0790	domini, implicad
Dhusia		Decedent's Name (First, Middle, La.	st)						2. Date of Death Month	Day	Year	3. Time of De	ath
Physic /Medi		Do	olores Marie	Perry					March 1	-	2006	7:55 P	м
Examir		4a. Facility Name (If not institution, give	e street and number)		4b. City, T	own, or L	ocation of	Death			ounty of De		
		69 Transverse Av				Midd	le Ri				Balt	imore Co.	
Funeral		5. Social Security Number 6. S 212-28-9505	ex 7. Age (In ) □ M 2□XF 7.5	vrs. last birthday, Yrs.		Year Days	If Under 2	4 Hrs. Min.	<ol> <li>Date of Birth (Month, Day,</li> </ol>	Year)	9. B	irthplace (State or Fo	oreign
Director		Usual Residence of Decedent		115.				c	Sept. 12	,193	3.0 P	ennsylvan	nia
and and		10a. State 10b. County	10c.	City, Town or L	ocation							10d. Inside City L	imits
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the 28a	Je C	10e. Street and Number			10f. Zip C	Code		411aa 1		n Citize	on of What C	Country?	
3a or		1922 Jasmine Roa	ad				21222	2				•	
be filed within 72 hours after death with the Maryland lat Hygene. d other than "naturel", or teme 23e or 28e-1 show avent, the Medical Exercites round by notified at	<b>Funeral Director</b>	11. Marital Status	12. Was Decedent Ever in	n U.S.   13.	Was Decede	ent of His	panic Origi	in? (Spec	of Ves or No-		Lted S	tates Berican Indian,	
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should to	ပု	Thomas Palmer					Est	her	Marie S	pand	gler		
2 sho		19a. Informant's Name/Relationship (	Type, Print)	19b. Maili	ing Address (	Street an	d Number	or Rural	Route Number,	City or 7	own, State,	Zip Code)	
and ealth n 27		Mr. Lee Perry	(Son)		Transv			. Mi	iddle Ri	ver,	, MD	21220	
of H of H of H or oth		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □	Demoval from State	<ul> <li>b. Place of Disposer</li> <li>cemetery, cre.</li> </ul>	osition (Name matory or oth	e of er place)		Da	te 2	0c. Loca	tion - City o	r Town, State	
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The law requires that the death certificate be executed tae has been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ 1√0 9 □ Unknown	23c. If yes, outcome of pred 1 □ Live birth 2 □ F 4 □ Pregnant at time of 9 □ Unknown	etal death 3[ of death 5[	□Ectopic preg □ Other (spec	cify)				230	d. Date of de Month	olivery Day Year	,
or Attending Physician: The law requires the after death.  Director: After this certificate has been signed in by the funeral director, page 2 should be de	þ	Part II. Other significant conditions or DEMENT	ontributing to death but not	resulting in the u	inderlying cau	ise given	in Part I.				_	o lhe cause of death robably 4 □Unkn	
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Attending Physician: n death. ector: After this certifica by the funeral director, p	0	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpatient 2	ER/Outpatier	nt 3 DOA	7 04			5 ☐ Residen	-	Other (Co.	Son s II	Cline
g Ph er th eral	H	27. Manner of Death	28a. Date of Injury (Month, Day Year,			: Injury a Work?			d. Describe how			city)	
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al or Atte s after de il Directo d in by th	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - Albuilding, etc. (Spe	t home, farm, str	reet, factory, o	office		28	f. Location (Stre City or Town,		lumber or R	ural Route Number,	
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To the within To the comp	M	29b. Signature and title of certifier			29c. L	icense n						th, Day, Year)	
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5		30. Name and address of person who a		tem 23a) (Type,	Print)	76	Eg	7	WISE 2	-04/	Ra	(TO. 7D2	1 17
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Registr		MAR 1 5 20	100	11 los	sales.								

State of Maryland / Department of Health and Mental Hygiene U 6 1 - For State Ragistre Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 2006 0.3 09 09:24 AM Harry F. Pippin, Jr. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Air, Mary Upper Chesapeake Medical Center Bel Maryland Harford Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Days 1**∑**M 2□ F Months Director 224-18-4645 83 07/18/1922 Tennessee Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a. State 10h County 27 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 No Directo Baltimore Baldwin 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21013 13009 Fork Road 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠ Yes 2 □ No If Yes, Give Year or Dates: WW I Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White, etc. 2 should be filed within 72 hours after and Mental Hygiene. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify. þ 3 X Widowed 4 ☐ Divorced WW II White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) C & P Telephone Co. 12 Engineer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Starling Esther Graves Harry F. Pippin, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 sh Depertment of Health and Important: If item 27 ie m eny injury or other traum once. 13021 Fork Road - Baldwin, Maryland Harry M. Pippin (son) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Metro Crematory, Inc. 03/13/2006 Baltimore, Maryland 4 □ Donation 5 □ Other (Specify) <sup>22. Name and Address of Facility</sup> E. F. Lassahn Funeral Home, P.A 11750 Belair Road - Kingsville, Maryland 21087 21. Signature of Funeral Service Licensee 00 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final a condispulmonalus **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine attending physicien and for use as the burial-transit Edular Htrial that initiated events resulting in death) Last Due to (or as a consequence of) Propin Harry# 085749 Division br vital Repords, P.O. Box 6876 Physician/Medical use as the 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) been signed by the a should be detached t 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 2 No 1 Yes funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 3 DOA 2 ER/Outpatient 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: 5 Pending 1 Naturai 1 ☐ Yes 2 ☐ No after death. investigation within 24 hours after death To the Funeral Director: , completely filled in by the f 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier 028486 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bol Ar Md 206 Hays St MD 32. Registrar's Signature 31. Date filed (Month, Day, Year) State il alia 5 2006 Registrar

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l.	Funeral Director		218-28-1681 Usual Residence of Decedent	1₫M 2□F 7		Yrs.	Months Days	Hours	Min.	B. Date of Birt (Month, Da June	y, Year) 17 1931	Mary	/land
	ne Maryland 8a-f show	Director	10a. State 10b. County  Maryland Anne A	rundel		, Town or Lo sadena					10- Chi-		0d. Inside City Limits 1 ☐ Yes 2 ☐ Xio
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30	be filed within 72 hours after death with the Maryland ital Hygiene. id other than "natural", or Itema 23a or 28a-f show avent, the Musical Evacilism counts be notified at	by Funeral	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 XDivorced	12. Was Decedent I Armed Forces?	Ever in U.S	1	Vas Decedent of H f Yes, specify Cuba		igin? (Spec n, Puerto R	ify Yes or No ican, etc.)	- 14. Ra	ace - America ack, White, e	etc.
1213-0030	filed within 72 hou Hygiene. ther than "natura snt, tre Medical	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)	Education	+)	(Give life. L	lent's Usual Occupa kind of work done of OO NOT use retired	during most	t of working	g	16b. Kind of		dustry
7 0	filed v Hygie other f		17. Father's Name (First, Middle, La	ist)		pii	umber_	18. Mothe	er's Name (	(First, Middle,	plumb Maiden Suma		
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gaitimore,	permit. Pages 1 and 2 Depertment of Heelth a Importent: If item 27 It any injury or other tre		20a. Method of Disposition  1  Burial 2  Cremation 3  4  Donation 5 Other (Spe	B □Removal from State	20b. Pl	ace of Dispo emetery, cren	sition (Name of natory or other place ematory I	(e)	3/15/0	ite	20c. Location	1	
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0	≥ .g D	n: To	1 Yes 27 No 27. Manner of Death	Hospital: 1 Inpatie	ry	ER/Outpatien 28b. Time of Injury	t 3 DOA	4 🗆 Nu			dence 6 0		7
UNISION	To the Hospitel or Attending Ph within 24 hours effer death. To the Funeral Director: Affer th completely filled in by the funeral	Certification:	1 Natural 5 Pending 2 Accident investiga 3 Suicide 6 Could no 4 Homicide determin	tion of be	ury - At ho	me, farm, str		Yes 2		Bf. Location (S City or Tox		nber or Rura.	l Route Number,
_	ne Hospitel n 24 hours ne Funeral bletely filled	edical Ce		Physicien: To the best of kaminer: On the basis of and manner sta	of my knov examinat ited.	wledge, death ion and/or in	occurred at the tin vestigation, in my o	ne, date an pinion, dea	nd place, ar ath occurred	nd due to the	cause(s) and r date and place	nanner as st e, and due to	ated. the cause(s)
	To the To the To the Comp	Me	29b. Signature and title of certifier		iD	1.0	29c. Licens	e number		70111	29d. Date sign	ned (Month, I	Day, Year)
	141		30. Name and address of person w	ho completed cause of d	eath (Item	23a) (Type,	Print)	0125	> ング	4164	10000	1916	NO 6
	Sta	to	Haddi Secka, MT 31. Date filed (Month, Day, Year)	) : UMMS . 32. Registra	ar's Signat	ture A	ene Sti	, 15h	Itma	ore, iv	11) 411	1+	
	Registr		MAR 1 5 20	06	S	JOSE .							

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195		1 - For Stete Registrer			Certificate of			Reg. No.	01304
Physi		1. Decedent's Name (First, Middle, GREGOR)			ROLLIN	15	2. Date of De Month March	Day Year 08, 2006	3. Time of Death
/Med Exam		4a. Facility Name (If not institution.) University of Ma	give street and number)		4b. City, Town,	or Location of Deat		4c. County of De	ath
Funera				n yrs. last birth		If Under 24 Hrs	8. Date of Bir (Month, Da MAV / 8	th 9. B	irthplace (State or Foreign Country)
		Usual Residence of Decedent  10a. State 10b. County	10	Oc. City, Town	or Location		TIMYTO	1	10d. Inside City Limits
death with the Maryland ime 23e or 28e-f ehow	Director	MARYLAND  10e, Street and Number	NIA		10f. Zip Code	LTIMOR	E CI	TV 10g. Citizen of What 0	1 X Yes 2 □ No
a with t	ă	525 MOSH	ER ST IST P	-L. APT	101. 240 0000	2121	7	4.5	A .
F E	Funerai	11. Marital Status 1 □ Never Married 2 Marrie	12. Was Decedent Eve Armed Forces? 1 1 1 1 1 No	or in U.S.	13. Was Decedent of If Yes, specify Cult	ban, Mexican, Puer	pecify Yes or No to Rican, etc.)	Black, Wh	
CD 0059	d by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:						3LACK
- ' ' '	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)	Education grade completed) College (1-4or 5+)	1	Decedent's Usual Occu 'Give kind of work done life. DO NOT use retire	e during most of wo	rking	16b. Kind of Busines	
N DOS.	Be Con	17. Father's Name (First, Middle, L	est)	100	RECTIONA		ne (First, Middle	STATE 0, , Maiden Sumame)	F MARYLAND
ylar ould b Manta Marked	10	CHARLES	ARTHUR		LLINS	DELO	RES E	DWINA	MARTIN
≥ 5 = 2 ±		ROCHELLE RO	LINS (WIF	E) 8	175T.1	AUL ST.	APT. 80 Date	er, City or Town, State	HD. 21202
0 0		20a. Method of Disposition  Burial 2 Cremation  4 Donation 5 Other (Spe	B □Removal from State	cemetery	Disposition (Name of r, crematory or other place) Soul ForE		16-06	DWINGS 1	UILLS MA.
Baltime parmit. Pag Dapartmant important: I		21. Signature of Funeral Service Li	censee	in ms	22. Name and Add	ess of Facility		JK. FUNE	RALHOME
		23a. Part1. Enter the disease, or o shock, or heart failure. List o	omplications that caused the	e death. Do no	ot enter the mode of dy	ring, such as cardia			Approximate Interval Between Dnset and Death
Physicia /Medica	ı	Immediate Cause (Final disease or condition resulting in death)	a. Gunshot wou Due to (or as a c						
Examine		Sequentially list conditions,	b. Due to (or as a c	onsequence o	fj:				
axacutad n and al-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as a c	onsequence o	f):				
			d						
Vision of Vital Records, P.O. Box 68760 attending Physician: Tha law requires that the death cartificate be rector: After this certificate has been signed by the attending physician by the tuneral director, page 2 should be detached for use as the buri	by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of a 1 □ Live birth 2 □ 4 □ Pregnant at time 9 □ Unknown	Fetal death	3 □Ectopic pregnan 5 □ Other (specify)	су		23d. Date of o Month	delivery Day Year
ds, Puiras that signad bid ba data		Part II. Other significant condition	s contributing to death but r	not resulting in	the underlying cause g	given in Part I.	1	v.	e to the cause of death?  Probably 4 □Unknown
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n of n of high high high high high high high hig	D: T	27. Manner of Death  1 □ Natural 5 □ Pending	28a. Date of Injury		ime of 28c. Injury	ury at ork?		how injury occurred	
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Div ital or A	Certification:	4 Alomicide determine	residence	Specify)			Baltimor	re, MD	Mosher St.
Division of Vital Rewither Hospital or Attending Physician: Tha I within 24 hours after daath. To the Funare I Director: After this certificate ha complately filled in by the funaral director, page	edicai	29a. Certifier 1 Certifying (Check only one) Medical E	Physician: To the best of r xaminer: On the basis of ex and manner stated	camination and	, death occurred at the dor investigation, in my	time, date and place opinion, death occ	e, and due to the urred at the time	, date and place, and d	due to the cause(s)
To the within 2 To the complain	×	29b. Signature and title of certifier	m.D			nse number		29d. Date signed (Md March 08,	
OKX	7	30. Name and address of person v	no completed cause of dear		Type, Print)				N 71
	State	31. Date filed (Months Pay Year)	5 2000 32. Registrar's	LII s Signature	Penn Stree	et, Baltin	nore, Ma	ryland 212	OT
Regi	strar	ment I	J LUUG MARCON	1. B.	Gordes .				

				1 - For State Registrar	State of Maryla		irtment of I		Mental Hygie	ZHUh	07905
				1. Decedent's Name (First, Middle, Las	it)	^	/	/	2. Date of Death Month	Day Year	3. Time of Death
		Physici /Medio		ALEXANDER	MERLE	KOB	INSON	SR.		2 2006	3:02 PM
		Examir		4a. Facility Name (If not institution, give				or Location of Death		4c. County of Death	10
	*				ALTH CARE	( (- )	BALT//		La Committee	N	1/7
		Funeral Director		5. Social Security Number 6. S	ex DAM 2□F	rs. last birthday)	Months Days		8. Date of Birth (Month, Day, Ye	ar) Cou	place (State or Foreign Intry)
				Usual Residence of Decedent		/Ψ			MARCH 07,	1930 171	PRYLAND
		ylanc		10a. State 10b. County	10c.	City, Town or Lo	cation		4		10d. Inside City Limits
		ith the Marylar or 28a-f show	ctor	MARYLAND N	IA		BA	LTIMOR	RE CIT	1/	1 ØYes 2 □ No
		death with the Maryland me 23a or 28a-f show rinust be notified at	Director	10e. Street and Number	/ 4		10f. Zip Code		10g.	Civizen of What Cou	intry?
		ath w		236 N. F		VENUE		2122	3	USA	-,
		er de Item	Funerai	11. Marital Status	12. Was Decedent Ever in Armed Forces?	1 U.S. 13. V	Vas Decedent of I Yes, specify Cub	Hispanic Origin? (Sp pan, Mexican, Puerto	pecify Yes or No- p Rican, etc.)	14. Race - Amer Black, White	ican Indian, , etc.
	36	urs after death with the Maryla al', or Iteme 23a or 28a-f shov Exantrier must be mulfied at	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☎ No If Yes, Give Year or Dates:	1	☐ Yes 2⊅ÎNo	Specify:		Specify:	ANV
	ò	2 should be filed within 72 hours after death wi and Mental Hygiene. Ie marked other then "natural", or iteme 23a raumatic event. The Medical Examiline must	ted	15. Decedent's Ed	lucation	16a. Deced	lent's Usuai Occu	pation	16b	. Kind of Business/Ir	ndustry
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	21	or th	Con	GTHGRADE			SUTC	HER	1	ARK SI	MUSAGE
	nd	be file	Be	17. Father's Name (First, Middle, Last)		- (	1	18. Mother's Nam	ne (First, Middle, Maid	fen Sumame)	1 -
	yla	ould Men narke	2	ALEXANDER		BINSON		EFFI		KAN	IE
	Baltimore, Maryland 21215-0036	ges 1 and 2 should be filed within to f Health and Mental Hygiene. If I tem 27 Is marked other then or other traumatic event, the Merical files.		19a. Informant's Name/Relationship (	(ype, Print)	19b. Mailin	1 -	1 12	ral Route Number, Cit	The State of the S	
	e,	1 and Healt em 2		20a. Method of Disposition	ON CUITE	o. Place of Dispo	N, FULI	1	Date 20c	Location - City or T	2/223 own, State
	5	Pages nent of I int: If It		1⊠Burial 2 ☐ Cremation 3 ☐	Removal from State	cemetery, cren	natory prother pla				
	Ħ	nit. P. artme britani Injury		4 ☐ Donation 5 ☐ Other (Specification of Funeral Service Licer		9/, 2/0	Name and Addre	ess of Facility	17-064	B FUNCUL	E,MD.
	Ba	permit. Pages 1 and 2 Department of Health a Important: If Item 27 le eny Injury or other trat		Wietich!	V. Wille	in ?	Name and Address of SEP	H FULTO	NAVE,	BALTO, M	PAL HOME 10 21217
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	4	/Medical Examiner		resulting in death)	Due to (or as a cons	sequence of):					
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E	89	ficate g phys	edic		. u.						
AND	Вох	n certific anding p	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pre-		le .			23d. Date of deliv	rery
7		death e atten ed for u	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant at time of		Ectopic pregnand Other (specify) _	ey .		Month	Day Year
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E		requires that the death certific een signed by the attending p nould be detached for use as i		Part II. Other significant conditions of	ontributing to death but not	resulting in the ur	nderlying cause gr	iven in Part I.		co use contribute to	the cause of death?
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d	မိုင်	₹ 0 75	pie	CORONARY A	CTERY DISEP	SE			24a. Was an autopsy	24b. Were aut	opsy findings available empletion of cause of
_	E.	The ate has page	Con						performed 1 ☐ Yes 2 🛣	? death?	
2	of Vital	clan: ertific ector,	Be	25. Was case referred to medical examiner?	(lassital)				th (Check only one)		
0	of	Physic this c	2	1 ☐ Yes 2 ☒ No  27. Manner of Death	Hospital: 1 Inpatient 2				ome 5 Residence		(y)
2		ding in. After funer	ion	1 KNatural 5 ☐ Pending	28a. Date of Injury (Month, Day Year	) Injury	28c. Inju Wo	ork? ☐Yes 2☐No	28d. Describe how in	njury occurred	
08/NSO	Division	deatl deatl ctor: y the	Certification:	3 ☐ Suicide 6 ☐ Could not b		t home, farm, str			28f. Location (Street	and Number or Ru	al Route Number
06	Θ	effer effer Dire	erti	4 Homicide determined	28e. Place of Injury - A building, etc. (Spe	ecify)	201, 140101 9, 011100		City or Town, Si	ate)	ar real or rambor,
X		To the Hospital or Attending Physician: The la within 24 hours effer death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2		(Check only 2 Medical Exam	ysician: To the best of my hiner: On the basis of exam	knowledge, death	occurred at the trestigation, in my	ime, date and place, opinion, death occur	and due to the cause	e(s) and manner as	stated.
		the the the the the the the the the the	Medical	one)	and manner stated.						
		5 × 5 × 5		29b. Signature and title of certifier  Manpulet	Mangat ,	10		9926		Date signed (Month,	
		-			1	11/		1126	141-	RCH 12	2006
		5		30. Name and address of person who 900, CATON AV		Item 23a) (Type, 71M0RE		) 21229	}		
		Sta	ite	31. Date filed (Month, Day, Year)	32. Registrar's Si		all -	- 1	•		
		Registi		MAR 1 5 28	ING States	M. And	A STATE OF THE PARTY OF THE PAR				

State of Maryland / Department of Health and Mental Hygiene [1] [1] [5] Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** Month March 14, 10:00 AMM Louise Pearl Rappe 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Holly Hill Manor Nurshing Home Baltimore Towson if Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Date of Birth **Funeral** 1 □ M 2 → F 83 216-36-9592 Yrs 02/09/1923 Director MD Usual Residence of Decedent with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Itema 23a or 28a-f ahow the Medical Examiner must be notified at Director MD 1 Yes 2 No Baltimore Towson 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 531 Stevenson Lane 21286 United States Funeral within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ∐Yes 20⊠No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: White Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry N/A and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Never Worked 0 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be nent of Health and Mental Henry Phillip Rappe Ruby Corrine Roberts 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If Item 27 is
any Injury or other trau Mrs. Jo Ann Harman/Niece 3667 Fissels Church Road Glen Rock, PA 17327 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a Method of Disposition 20c. Location - City or Town, State Mar 17 1 ⊠Burial 2 □ Cremation 3 □ Removal from State Parkville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Parkwood Cemetery 2006 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Cremation and Funeral Alternatives da Due 1101443 8717 Green Pastures Drive Baltimore, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** O day neumonia /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, any leading to intractials cause. Enter Underlying Cause (Disease or injury Due to (or as a consequency of) Examine certificate be executed physician and s the burial-transit resulting in death) Last Due to (or as a consequence of) Box 68760, Physician/Medicai as the attending | IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery The law requires that the death 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) signed by the a Id be detached f 1 ☐ Yes 2 ☐ No o 9 Unknown 9 Unknown ۵. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Š 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Inknown Completed peeu 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? hes autopsy performed certificate 1 Yes 2 No 1 ☐ Yes 2 No of Vital or Attanding Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 Ø No ٢ 1 Inpatient 2 ER/Outpatient 3 DOA this After thi 28a. Date of Injury (Month, Day Year) Certification: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Division 5 Pending investigation 1 Natural death. 1 ☐ Yes 2 ☐ No Il Director: / 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 | Homicide hours after within 24 hours a To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) GW 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Houk Ø 31. Date filed (Month, Day, Year) MAR 1 5 32 Registrar's Signature State Registrar

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Or Co.

			a FOI	partment of Health and Menta Prtificate of Death	Reg. No.	6 0/90/
Ī	Physici	an	1. Decedent's Name (First, Middle, Last) Prince Richardson		e of Death	3. Time of Death
·	/Media	al				
	Examir	er	4a. Facility Name (If not institution, give street and number)  1429 N. Ellamont Street	4b. City, Town, or Location of Death	4c. County of N/A	Death
i	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda	y) If Under 1 Year If Under 24 Hrs. 8. Date Months Days Hours Min. (Mo.	e of Birth 9 nth, Day, Year)	. Birthplace (State or Foreign
	Director		243-40-7304 1XM 2□F 75 Yrs.		4-21-1930	N.C.
	land ow		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or	Location		10d. Inside City Limits
	Mary Iled	tor	Md N/A Balto			1√ Yes 2□No
	th the	Director	10e. Street and Number	10f. Zip Code	10g. Citizen of Wha	at Country?
	ath wi	rai 🏻	1429 N. Ellamont Street	21216	USA	
336	filed within 72 hours after death with the Maryland Hygiene. yther than "natural", or items 23a or 28a-f show ent, the Medical Examiner must be motified.	by Funerai	11. Marital Status  1 □ Never Married 2 □ Married  3 ☒ Widowed 4 □ Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Yes 2 ☒ No If Yes, Give Year or Dates:	<ol> <li>Was Decedent of Hispanic Origin? (Specify Yelf Yes, specify Cuban, Mexican, Puerto Rican, €</li> <li>□ Yes 2 √√√√ No Specify:</li> </ol>	s or No- atc.) 14. Race - Black, 1 Specify: P	American Indian, White, etc. Black
9200-91212	be filed within 72 hours aft ital Hygiene. Ind other than "natural", or event, I'm Medical Exam	Completed	15. Decedent's Education 16a. Dec (Specify only highest grade completed) (Gi	edent's Usual Occupation	16b. Kind of Busin	ness/Industry
7	han "	mpie	Elementary/Secondary (0-12) College (1-4or 5+)	re kind of work done during most of working DO NOT use retired)	Bethlehe	m Steel
-	filed v Hygie other t		8th grade N/A  17. Father's Name (First, Middle, Last)	Millwright  18. Mother's Name (First.	Sparrows	Point
Maryland	be d all	To Be	Enoch Richardson	Pattie West	,,	
ary	2 should and Men ie marke aumatic	-		ling Address (Street and Number or Rural Route		ate, Zip Code)
_	and alth			7 Heathermore Blvd Up	per Marlboro	, Md 20772
saltimore,	permit. Pages 1 a Department of He Important: If for any njury or oth		V odust 5 □ Cremation 3 □ Hemoval from State	position (Name of ematory or other place)  Wn Cemetery 3-16-200	20c. Location - Cit Balto, M	•
Dalt	permit. Departi Import			22. Name and Address of Facility March 4300 Wabash Avenue Bal		5
			23a. Part1. Enter the disease, or complications that caused the death. Do not eshock, or heart failure. List only one cause on each line.	nter the mode of dying, such as cardiac or respire	atory arrest,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death)  A Card	in Infurction		Onset and Death Miny 4 mg
	/Medical Examiner		Due to (or as a consequence of):			7.100
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y	cuted od ransit	Examiner	Sequestically first conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events			
Š	e exe ian ar urial-t	EX	resulting in death) Last Due to (or as a consequence of):			
<b>68/6</b> 0,	tificate be executed ig physician and as the burial-transit	ledical	d.			-
O. BOX 6	death certifi e attending id for use as	Physician/Me		□Ectopic pregnancy □ Other (specify)	23d. Date o Month	f delivery Day Year
ທົ່ ນັ	requires that the de been signed by the a hould be detached f	by Pr	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I. 236	e. Did tobacco use contribu	ite to the cause of death?
	w require been si should l	ted	Prostate Canter		1 ☐ Yes 2 ☑ No 3 [	Probably 4 Unknown
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Vital	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	26. Place of Death (Check		
ō	Z ≥ D	5.	27. Manner of Death 28a. Date of Injury 2Bb. Time	Sit 3 DOA 4 Nuising Home 35	esidence 6 Other (	(Specify)
0	Attending ir death. ector: After by the fune	ation	1 ☑ Natural 5 ☐ Pending (Month, Day Year) Injury 2 ☐ Accident investigation	Work? M 1 □ Yes 2 □ No		
DIVISION	ei or Attenos aftar death i Director: d in by the	Certification;	3 ☐ Suicide 6 ☐ Could not be determined 2Be. Place of Injury - At home, farm, so building, etc. (Specify)	street, factory, office 28f. Loc. City	ation (Street and Number of or Town, State)	or Rural Route Number,
	To the Hospitel or Attending Ph within 24 hours aftar death. To the Funerel Director: After th completely filled in by the funeral	Medical C	29a. Certifier (Check only one)  Sertifying Physician: To the best of my knowledge, de 2 Medical Examiner: On the basis of examination and/or and manner stated.	ath occurred at the time, date and place, and due investigation, in my opinion, death occurred at the	to the cause(s) and manne time, date and place, and	er as stated. I due to the cause(s)
	To the To the Comp	Σ	29b. Signature and title of certifier	29c. License number	29d. Date signed (A	Month, Day, Year)
1	0		1 / MA	10033330	3/14	12006
	1.2		30. Name and address of person who completed cause of death (Item 23a) (Typ	3333 N. CALVERI	ST. #66 21218	0
	Sta Registr		31. Date filed (Month, Day, Year) 32. Registrar's Signature			

			State of Maryland / Department of State of Maryland / Department of Certificate			ene 0 0 6	07908
	Physicia	an	1. Decedent's Name (First, Middle, Last)  Jasper Lee Roy		2. Date of Death	Day, Year	/ / / / / 1
	/Medic Examin			own, or Location of Death	10401	4c. County of Dea	0
	ZAMIIII	·		kville		Balto	
200	Funeral Director		5. Social Security Number 6. Sex 1. Age (In yrs. last birthday) 1. Under 1. Age (In yrs. last birthday) 1. Months 1. Months 1. Age (In yrs. last birthday) 1. Months 1. Age (In yrs. last birthday) 1. Age (In yrs. last	Year If Under 24 Hrs.  Days Hours Min.	8. Date of Birth (Month, Day, Y 7-18-1	9. Bi	rthplace (State or Foreign Country)
7	pu ,		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
13	h the Marylar or 28a-f show	ō					12 Yes 2 No
	28a-1	rect	Md N/A Balto  10e. Street and Number 10f. Zip C	ode	10g	. Citizen of What C	ountry?
2	h with	<u>i</u>	3816 Fernhill Avenue	21215		USA	
2	ems sermi	Iner	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Deceder Armed Forces? 11. Marital Status 12. Was Deceder Hyper in U.S. 13. Was Deceder Hyper in U.S. 14. Was Deceder Hyper in U.S. 15. Was Deceder Hyper in U.S	nt of Hispanic Origin? (Spe y Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Wh	
38	urs afte	by Funeral Director	1 ⚠ Never Married 2 ☐ Married 1 ☐ Yes 2 ☒ No If Yes, Give 1 ☐ Yes 2 ☒ No Year or Dates:	No Specify:		Specify: B	lack
2-0(	72 hou	ted	15. Decedent's Education 16a. Decedent's Usual ( (Specify only highest grade completed) (Give kind of work	Occupation done during most of working retired)	ina 16	b. Kind of Business	
121	I within 72 ho liene. r than "natui the Madical	Completed	Elementary/Secondary (0-12) College (1-4or 5+) 11th grade N/A Self Emplo			Auto Mec	hanic
d 2	be filed vital Hygie of other if	Be Co	17. Father's Name (First, Middle, Last)		e (First, Middle, Ma	iden Sumame)	
/lan	Menta Menta arked arfc ev	To B	George Washington Roy	Lillian	Thomas		
Maryland 21215-0036	and 2 should be filed within 72 hours after death with the Maryland beith and Mental Hygiene. In 27 is marked other than "natural", or items 23a or 28a-f show her traumatic event, the Medical Examiner must be nutilised at	12		Street and Number or Rura ondson Avenu			Zip Code)
<b>.</b>	r Heel		20a. Method of Disposition 20b. Place of Disposition (Name	of		c. Location - City o	r Town, State
E O	Pages nent of I int: if it		1X Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)  King Memorial	Park 3-14	100	Randallst	own, Md
Baltimore,	permit. Pages 1 and 2 Department of Heelth a important: if item 27 te any injury or other tra pnce.		21. Signalule of Funeral Service Licensee 22. Name and		arch F/H ash Avenu		Md 21215
			23a. Part Enter the disease, or complications that caused the death. Do not enter the mode shock, or heart failure. List only one cause on each line.	of dying, such as cardiac	or respiratory arres	t,	Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	+ lung			Onset and Death
	/Medical Examiner		Puerto (or as a consequence of):	o deficis	ncy Viva	s infortio	221
T.	¬ =	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury			7.7.0	
,	ate be executed only siclen and the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):				
8760,	te be e ysicler ne burie	dicai E	d				
9	entifica ling ph e as th	Med	IF FEMALE:				
Вох	leath certific attending pl	Physician/Me	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No			23d. Date of de Month	elivery Day Year
.0.	at the de by the a tached	hysi	9 Unknown				
Division of Vital Records, P.O.	luires tha n signed I	ρ	Part II. Other significant conditions contributing to death but not resulting in the underlying cau	use given in Part I.			to the cause of death?  Probably 4 DUnknown
1000	e law requir has been si je 2 should	ompieted			24a. Was an autopsy	24b. Were a	autopsy findings available completion of cause of
= R	The rete has page	Com			performe	d? death? 2 No 1 □ Ye	
Vita	iclan: Sertific ector,	Be	25. Was case referred to medical examiner?  Hospital:	Othor	th (Check only one)		
of	ding Physician: The I h. After this certificete ha funeral director, page	7. To	1 Inpatient 2 Envoutpatient 3 DOA	4 Nursing Ho	ome 5 Resident		ecify)
ion	ath. arth. or: Afte	ation	2 Accident investigation	Work? 1 ☐ Yes 2 ☐ No			
Divis	or Atter de Directe	Certification:	3 Suicide 4 Homicide  6 Could not be determined  28e. Place of Injury - At home, farm, street, factory, building, etc. (Specify)	office	28f. Location (Stre City or Town,		Rural Route Number,
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical Co	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at 2 Medical Examiner: On the basis of examination and/or investigation, is and manner stated.				
	To the within To the comple	Me	20h Signature and till a of certifier	License number	290	d. Date signed (Mor	nth, Day, Year)
	V		Allen Attending Physicia	M 0531	645 /	Tark	92006
_	1		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  A 2 H 3 560 60 60 600	on Blud	303 Ba	Ct, more	- 21239
	Sta Registi		31. Date filed (Month, Day, Year) MAR 1 5 2006				

			For State Registrar	State of Marylan		artmen rtificat			nd <b>M</b> e		giene Reg. No.	006	07909
,	40.7		1. Decedent's Name (First, Middle, Last)						2	2. Date of Dea	ath Day	Year	3. Time of Death
*	Physicia /Medic			Dorothy G	. Some	rs				March	9, 2	2006	6:00 P M
	Examin		4a. Facility Name (If not institution, give s	·		4b. City,	Town, or	Location of	Death		4c. (	County of Deat	h
			1923 Midland Road			16 1 1 2 - 12 - 1		dalk	A Hro T			Baltimo	
	Funeral		5. Social Security Number 6. Sex	M 2XIE	ast birthday) Yrs.	Months	1 Year Days	If Under 2 Hours	Min.	3. Date of Birt (Month, Da)	y, Year)		hplace (State or Foreign untry)
Nege Nege	Director		232-46-2878 Usual Residence of Decedent	73	113.	l				March	11,1	L932 W	est Virginia
	land bw	Ì	10a. State 10b. County	10c. City	, Town or Lo	ocation							10d. Inside City Limits
	Mary	ţō	Maryland Balt	timore			ח	undal!	ŀ				1 ☐ Yes 2X No
	r 28a	Director	10e. Street and Number			10f. Zip		direct.	4.5		10g. Citiz	en of What Co	ountry?
	3a o	O is	1923 Midland Road	i			2	1222			Unit	ed Sta	tes
	deatl	Funerail	11. Marital Status	12. Was Decedent Ever in U. Armed Forces?	S. 13.	Was Deced	dent of Hi	spanic Orig	in? (Spec	ify Yes or No-		4. Race - Ame Black, Whit	ncan Indian,
ဖွ	after or its	F	1 Never Married 2 Married	1 ☐ Yes 2 ☐ <b>X</b> No If Yes, Give		1 ☐ Yes		Specify:		,		Specify:	0,010
21215-0036	ural',	d by	3 Widowed 4 □ Divorced	Year or Dates:									White
<u>7</u>	within 72 hours after death with the Maryland ene. Than "neturel", or tiems 28s or 28s-f show Its Modest Exemities must be notified at	Completed	15. Decedent's Educ (Specify only highest grade	cation completed)	(Give	dent's Usua kind of wo DO NOT u	rk done d	during most	of working	9	16b. Kir	nd of Business/	Industry
2	Mithic shen shen	E D	Elementary/Secondary (0-12)	College (1-4or 5+)		memak		,				0	
D D	Hygie ther int, ii	S	17. Father's Name (First, Middle, Last)		по	шешак	ET	18. Mother	r's Name (	First, Middle,	Maiden .	Own Hot Sumame)	ne
au	d be ontal	To Be	William McKinley	/ Hovermale				5	Svvil	lia Fr	ance	s Marsl	nall
Maryland	Shoul of M mari	F	19a. Informant's Name/Relationship (Type		1) 19b. Maili	ng Address	(Street a						
S	od 2.		Mr. Andrew Middl	leton	431	9 Ken	wood	Ave.	Bal	timore	, Ma	ryland	21206
ē,	f Hea f Hea itsm othe		20a. Method of Disposition	l c	lace of Dispo	osition (Nar	me of other plac	(a)	Da	te	20c. Lo	cation - City or	Town, State
E	Page ento nt: If ry or		1 ☑ Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State					3 /1	3/2006	Berl	celey S	prings, WV
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Depertment of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23s or 28s-f show amy injury or other traumatic avant, Ins Machal Examiner must be purified at any injury or other traumatic avant, Ins Machal Examiner must be purified at angles.		21. Signature of Funeral Service License	90	2	<ol><li>Name ar</li></ol>	nd Addres	ss of Facility	/				
ä	Depermine permine	to Dance	Masse	er !	uda-F 7922 I	Ruck Wise	Funer Ave.	al Ho Dun	dalk,	Mary	dalk, I land 2	21222	
	**************************************		23a. Part 1. Enter the disease, or compli- shock, or heart failure. List only on	ications that caused the death						respiratory a		32.0	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Lour	Ca	uc	حار ع						Mou Hu
	/Medical		resulting in death)	Due to (or as a conseq									
	Examiner		Sequentially list conditions,	),									
	D #	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to for as a conseq	uanea of):								
P	and -trans	cam	that initiated events resulting in death) Last	Due to (or as a conseq	tience of):	_			_				
8760,	icate be executed physicien and s the burial-transit			Due 10 (01 us a conseq	derice (1).								
87	physics the b	dicai	d	d									
9 ×	law requires that the death certific: as been signed by the attending pl 2 should be detached for use as i	Physician/Med	IF FEMALE: 2	3c. If yes, outcome of pregna	ancv							23d. Date of de	livery
Box	atten for u	ian	in the past 12 months?	1 Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d	death 3	Ectopic p Other (s		,				Month	Day Year
0	by the de	iysic	1 ☐ Yes 2 Ø No 9 ☐ Unknown	9☐ Unknown			7,						
<u> </u>	igned by		Part II. Other significant conditions con	ntributing to death but not res	ulting in the	underlying o	cause giv	en in Part I.		23e. Did t	obacco u	se contribute t	o the cause of death?
Records,	uires n sign	d by								1 🗹	Yes 2	□No 3□P	robably 4 Unknown
OS	w require been si should I	lete								24a. Was		24b. Were a	utopsy findings available
Re	The law sete has page 2:	Completed								autor perfo	ormed? 2 No	death?	completion of cause of
	ician: T certificat rector, pa	Ö	25. Was case referred to medical					26. Place	of Death	(Check only of		1.0.10	-
>	9 w 7	To B	examiner?	Hospital:	ER/Outpatie	int 3□ D	OA Oth	er: 4 🗆 Nui	rsing Hom	e 5 Resi	dence 6	3 ☐Other (Spe	ecify)
0	ding Phy h. After thi funeral		27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of	of	28c. Injun	y at	2	8d. Describe	how injur	y occurred	
o	Attending r death. ector: After by the fune	atio	1 Natural 5 Pending 2 Accident investigation	(William Buy Four)	,.,	М		Yes 2□N	No				
Division of Vital	i or Attend after death i Director: d in by the f	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At his building, etc. (Special		treet, factor	y, office		2	8f. Location ( City or To			ural Route Number,
Ö	rs aft ai Di	Cer											
	To the Hospital or At within 24 hours after or To the Funeral Direct completely filled in by	edicai		sician: To the best of my kno ner: On the basis of examina and manner stated.									
	To the within 2 To the comple	Me	29b. Signature and title of certifier	10	^	29	c. Licens	e number				e signed (Mon	
	,- ,- 0		) CiA	Me u			170	t16	14	ا غ	MI.	HUSCH	10, 2006
•	6		30. Ame and address of person who co		m 23a) (Type		(()	./\	0	17	1		212 76
I.			31. Date filed (Month, Day, Year)	e ⊢ 9.2 32 Registrar's Signa	ature C	cey	ue ( )	V 4 (	UK	122	VIL	uns	CVC 10
	St Regist	ate rar	MAR 1 5 200	S Frederica A	· An	See B							

1	For State of Maryland	/ Department of Health and MacCertificate of Death	ental Hygiene () () 6 () 79 ()
	Hegistrar  I. Decedent's Name (First, Middle, Last)		Date of Death     3. Time of Death
Physician /Medical	Beulah Weber Sarpalis		Month Day Year 7:25p M  March 11 2006 7:25p M
Examiner	Na. Facility Name (If not institution, give street and number)  Manor Care –Ridge Road	4b. City, Town, or Location of Death  Rosedale	Baltimore
Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. la	100000000000000000000000000000000000000	8. Date of Birth (Month, Day Year) 9. Birthplace (State or Foreign Country)
Director	212-24-7840 1 <sup>1</sup> M 2C) 93		ec.26,1912 WestVirginia
0	Usual Residence of Decedent 10a. State 10b. County 10c. City,	Town or Location	10d. Inside City Limits
Mary Misch Misch	MD Baltimore Mi	ddle River	1 ☐ Yes 2 ☐Nto
fiter death with the Mar ritems 28s or 28s-1 st niner must be notified Funeral Director	10e.Street and Number 3509 Bay Drive	10f. Zip Code 21220	10g. Citizen of What Country? USA
21215-0036  I within 72 hours after death with the Maryland liene. I than "neture!", or Itema 23a or 28a-1 show the Marical Examiner must be notified at completed by Funeral Director	11. Marital Status  1 □ Never Married 2 □ Marned  3 ▼ Widowed 4 □ Divorced  12. Was Decedent Ever in U.S Armed Forces?  1 □ Yes 2 □ ₩ No II Yes, Give Year or Dates:	i. 13. Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto	Black, White, etc.  Specify: White
21215-00 21215-00 ed within 72 hou yajenen er than "neture t, the Modeal E Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)	16a. Decedent's Usual Occupation (Give kind of work done during most of workilife. DO NOT use retired)  Registered Nurse	Public Health
be filed that Hygher event,	17. Father's Name (First, Middle, Last)  Frank Weber		(First, Middle, Maiden Surname)
aryla	19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rura	
	Karl Sarpalis /son	3509 Bay Drive Bal	
0 00	Ce Ce	ace of Disposition (Name of metery, crematory or other place) Lawn Cemetery 3/15	/06 20c. Location - City or Town, State Baltimore MD
Baltimo	21. Signature of Funeral Service Licensee		nnellyFuneralHomeofEssex
ш аос • а	23a. Part1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line.	300 MACE AVE. B	altimore MD 21221 or respiratory arrest, Approximate
Physician /Medical	shock, or heart failure. List off one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. ATHERIOSCI  Due to (or as a consequence)	EROTIC CARDIOVASCO	Interval Between Onset and Death UCAR DISEASE VEALS
8760, State be executed expression and the burial-transit and dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  b. Due to (or as a consequence of the consequen		
Box 6 death certifications a strending post of for use as	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  23c. If yes, outcome of pregnant 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de 9 □ Unknown	death 3 Ectopic pregnancy	23d. Date of delivery Month Day Year
IS, P.O.	Part If. Other significant conditions contributing to death but not resu	ilting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?
cords w requires been sig should b	DEMENTIA		1 Yes 2 No 3 Probably 4 Officknown
Vital Records, sicien: The law requires t certificate has been signe lirector, page 2 should be e	ATRIA FIBRILLATION	<i>)</i>	24a. Was an autopsy findings available prior to compfetion of cause of death?  1 Yes 2 No
of Vital Physicien: Tribis certificat ral director, p	25. Was case referred to medical examiner?		h (Check only one)
of Vita Physicien: r this certificated director,			me 5 Residence 6 Other (Specify)  28d. Describe how injury occurred
on on iding th.  After stuner stuner	27. Manner of Death    Matural   5   Pending   2   Accident   Accident   28a. Date of Injury (Month, Day Year)	28b. Time of Injury M 28c. Injury at Work?  M 1 Yes 2 No	
Division of Vital Re To the Hospital or Attending Physicien: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page Medical Certification: To Be Com	ST Could not be	me, farm, street, factory, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)
To the Hospital within 24 hours of To the Funeral completely filled	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my known and manner stated.	wledge, death occurred at the time, date and place, tion and/or investigation, in my opinion, death occur	and due to the cause(s) and manner as stated. red at the time, date and place, and due to the cause(s)
To th withir To th comp	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
0.	30. Name and address of person who completed cause of death (Item	23a) (Type, Print)	# MARCH 142006 BARTIMERZE MD 21201
	NANA CEASAS 821 NOVLT  31. Date filed (Month, Day, Year) 32: Registrar's Signa	H EUTAW STREET	BAZTIMORZE M1) 21201
State Registrar	31. Date filed (Month, Day, Year) MAR 1 5 2006	South.	
DHMH 17 Rev 1/2001		ORIGINAL	

			1 - For State Registrar		State of M	larylar		artmeni rtificate			and M	ental Hy	giene Reg. No	2 U U	5	07	911
	Dhuois		Decedent's Name (First	t, Middle, Last	)							2. Date of D			ear	3. Time	of Death
	Physic /Medi		REGINA		NOS							MARCI				3:0	7 AM
)	Exami	ner	4a. Facility Name (If not in	nstitution, give		0		1		Location o			i	. County of	Λ .		
			5. Social Security Number	6. Se			UTER last birthday)		LEN	If Under:		8. Date of Bi		INNE		UNDE	
	Funeral Director		217-14-0056		М 2. ДЕ Г	83		Months	Days	Hours	Min.	Jan 2,	av Year		Coun	try)	e or Forei <b>g</b> n
			Usual Residence of Dece	dent								oun 2,	172	J 111	aly.	Lanu	
	ehow			County			ty, Town or Lo								11		City Limits
	Ba-f	cto		ne Arun	idel 	Mil	1ersvi										es 2√∑No
	with th	Dire	10e. Street and Number					10f. Zip						tizen of Wh	at Coun	try?	
	eath rs 23	erai	8305 Hope Po	orne ce	12. Was Deceden	Ever in I	S 12	2110		enanio Orio	nin? (Sno	cify Yes or N	U.S	. A . 14. Race -	Amoria	an Indian	
"	s 1 end 2 should be filed within 72 hours after death with the Maryland I Health end Mental Hygiene. Item 27 ie marked other then "natural", or Items 23a or 28a-1 show other treumatic event, the Medical Examinar must be notified at	Funeral Director	1 Never Married 2	Married	Armed Forces	?		If Yes, spec	ify Cubai	n, Mexican	, Puerto	Rican, etc.)	0-		White,		
98	al', o	þ	3∑ Widowed 4 □ D	ivorced	If Yes, Give Year or Dates:	•		1 ☐ Yes 2	KXN0	Specify:				Specify: 1	whit	e	
Maryland 21215-0036	72 hc	Completed		ecedent's Edu y highest grad				dent's Usua kind of wor			of worki	na	16b. K	ind of Busin	ness/Inc	lustry	
7	ithin nen hen	mpi	Elementary/Secondary		College (1-4or	5+)	life.	DO NOT us	e retired)	i i i i i i i i i i i i i i i i i i i	or working	<i>'</i> 9					
2	filed v Hygie other t		17. Father's Name (First,	Middle I ast)	1		Nurse	-		10 Motho	r'o Namo	(First, Middle		1th Ca	are		
anc	2 should be filed withir end Mental Hygiene. ie marked other then eumatic event, Ir.e.Mi	Be c	George H. Mi											Sumame)			
$\leq$	should and Men marke umatic	10	19a. Informant's Name/R		/pe, Print)		19b. Maili	na Address				Winche   Route Numb		or Town St	ate Zio	Codel	
S	ad 2 state of 1 state		Bruce C. Sin									llersv					
ē,	s 1 end 3 if Health item 27 other tr		20a. Method of Dispositio	n			Place of Dispo	sition (Nam	e of			ate		ocation - Ci			
Ë	Pages nent of int: if it		1 □ Burial 2 ☑Crei 4 및 Donation 5 □ 0								3-1	4-2006	0de:	nton,	MD		
Baltimore,	permit. Pages 1 end 2 Department of Health e Important: If item 27 is eny injury or other tre once.		21. Signature of Funeral	Ambrose Funeral Home, Inc.													
<u>m</u>	8858		Daniel	22. Name and Address of Facility Ambrose Funeral Home, Inc. 1328 Sulphur Spring Rd. Arbutus MD 212  3a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.													
			23a. Part1. Enter the disc shock, or heart failu	ease or complete. List only of	lications that cause ne cause on each	d the deat line.	h. Do not ent	er the mode	of dying	, such as	cardiac o	r respiratory a	arrest,			Approxim	Between
7	Physician		Immediate Cause (Final disease or condition	100	SEPTI	i Si	10CK								-	Onset an	d Death
1	/Medical Examiner		resulting in death)		Due to (or as	a conseq	uence of):										13
Н		_	Sequentially list condition	s,	Due to (or as	HOW	A A									3 04	24
J	nsit	Examine	if any, leading to immedia cause. Enter Underlying Cause (Disease or injury	" ⊀	200 10 (51 2.	a conseq	derice or).										
ŕ	execunance nance ial-tra	Exa	that initiated events resulting in death) Last	1	Due to (or as	a conseq	uence of):				·				+		
8760,	The law requires that the death certificate be executed site has been signed by the attending physicien and page 2 should be deteched for use as the burial-transit	dicai			d												
9	ntifica ng ph as th	0	IS SEMALS														
Вох	eath certific attending p	an/h	IF FEMALE: 23b. Was decedent pregr	iant	23c. If yes, outcome 1 ☐ Live birth			Ectopic pre	gnancy					23d. Date o		•	
	by the at teched for	Physician/M	in the past 12 month 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	Sr	4☐Pregnant a 9☐Unknown	t time of d		Other (spe					-	Month		Day	Year
P.0	thet the		Part II. Other significant	conditions co	otributing to death i	out not rec	ulting in the u	ndoch ing ee	1160 611/0	n in Part I		230 Did	tobassa	use contribu	to to th		4 4
of Vital Records,	signed be de	Completed by	COPD		ninosting to doutin	Jul 1101 103	daing ar the d	ndonying ca	use give	maraiti.					_ Proba		Unknown
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Re	The lav	E C										24a. Was		prio	r to com th?	pletion of	s available cause of
ta	iclen: Th certificete ector, pag	ပိ	25. Was case referred to	medical						OC Place	of Darah	1 Yes	2 <b>P</b> No		Yes	2 P No	
>	Physicien: this certifica al director, I	To B	examiner? 1 ☐ Yes 2 🖢 No		lospital: 1 (Inpati	ent 2	ER/Outpatier	it 3□ DO/	Othe	~		(Check only ne 5 ☐ Resi		6 Other	Spanific		
10	ding Phi h. After thi funeral		27. Manner of Death	(D- 1)	28a. Date of Inj	ury	28b. Time of		c Injury Work			8d. Describe			эрөспу		
Sio	Attendir death. ctor: Af y the fu	atic	2 Accident	Pending investigation	(	, , , ,		М		es 2 N	10						
Division	or Att	Certification:	3 ☐ Suicide 6 ☐ 4 ☐ Homicide	Could not be determined	28e. Place of In building, e	jury - At he tc. (Specif	ome, farm, str	eet, factory,	office		2	8f. Location ( City or To	Street ar	d Number (	or Rural	Route Nu	ımber,
	urs el																
	To the Hospital or Attending within 24 hours effer death.  To the Funeral Director: Attercompletely filled in by the funer	Medical	29a. Certifier 1 TC (Check only 2 N	ertitying Physiodical Exami	sician: To the best ner: On the basis of and manner si	ot examina	wledge, deatl tion and/or in	n occurred a vestigation,	it the time in my opi	e, date and inion, deat	d place, a h occurre	nd due to the d at the time,	cause(s date and	and manne place, and	er as sta due to	ited. the cause	o(s)
	o the ithin 2 o the omple	Me	29b. Signature and title of	certifier	and mainers			29c.	License	number			29d. Da	te signed (A	Aonth. E	Dav. Year)	
	⊢ \$ ⊢ ō		► Coliborn	m). Cose	masses. H	a.		1	100	65.	414			CHI			
	10		30. Name and address of			death (Iten	1 23a) (Type.		0 00	, •			1-161	14	, ~ )		, 10
	10		GUILLERI			•	301		TAL	DRIVE	10,	18 43	URUi	EIMD	,21	130	
	Sta		31. Date filed (Month, Day	, Year)	32. Regist			and o			, -		- 1 - 10				
	Registr	ar	MAD	1 5 20	RG Mari	100	Je Jan	in Charles									

				1 - For State Registrar	State of N	Marylan		artment <i>rtificate</i>		ealth and N Death	Mental Hy	giene	06	07912
_		Physicia /Medic		Decedent's Name (First, Middle, La Annabelle W Schm							2. Date of Do		Year	3. Time of Death 10:50 A <sub>M</sub>
		Examin		4a. Facility Name (If not institution, gi Genesis Eldercare	ve street and number Franklinwood	or) ds		4b. City, To Baltin	own, or l	cocation of Death		Balt	unty of Death LMOTE	
		uneral rector			Sex 1 □ M 2X□ F	Age (In yrs 95	last birthday) Yrs.	If Under 1 Months	Year Days	If Under 24 Hrs. Hours Min.	8. Date of Bi	<sup>nh</sup> 2 1910	9. Birthi	place (State or Foreign Imore , Mary Lanc
	aryland	det		Usual Residence of Decedent  10a. State 10b. County			y, Town or Lo	ocation						10d. Inside City Limits
	with the Ma	a or 28e-f	Director	Maryland Baltimore  10e. Street and Number  10920 Raphel Road		КП	gsville	10f. Zip C				10g. Citizen	of What Cou	1 □ Yes 2X No intry?
<i>(</i>	<b>336</b> urs after death	Important: If item 27 is marked other then "naturel", or items 23s or 28e-f ehow any injury or other treumstic event, I're Medical Exercities result be ricitified at once.	by Funeral	11. Marital Status  1 Never Married 2 Married  XX Widowed 4 Divorced	12. Was Deceder Armed Force 1  Yes 27 If Yes, Give Year or Dates	s? ]No		Was Deceder	nt of His y Cuban	panic Origin? (Sp., Mexican, Puerto	pecify Yes or No Rican, etc.)	0- 14.	Race - Ameri Black, White, ecify:	
9,40	21215-0036 od within 72 hours aft giene.	then "nature the Madical E	Completed	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12)	Education ade completed)  College (1-40	r 5+)	16a. Dece (Give life. Housew		Occupat done du retired)	ion Iring most of wor	king		of Business/In	
Schwidt	Maryland 2 id 2 should be filed ith and Mental Hyg	rked other	To Be C	17. Father's Name (First, Middle, Las William Witt	t)			A. M. A. M. A. M. A. M. A. M. A. M. A. M. A. M. A. M. A. M. A. M. A. M. A. M. A. M. A. M. A. M. A. M. A. M. A.		18. Mother's Nam Margaret			name)	
J.	, Mary and 2 sho	n 27 is ma er treuma		19a. Informant's Name/Relationship Thomas Schmidt	(Турө, Print)		19b. Maili 6 Fox	ng Address (S Hill Co	Street ar	Perry hal	ral Route Numb L1, md. 2	per, City or To 1128	wn, State, Zip	> Code)
	Baltimore,	ant: If iten ury or oth		20a. Method of Disposition  1 Burial 2 Cremation 3 5 4 Donation 5 Other (Special Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Con		0	emetery, crei	esition (Name matory or othe atory Ir	er place		Date 006		on - City or To re,Mary.	
	Ball Permit Depart	any in		21. Signature of Funeral Service Lice	to be	(a)		1750 Be]	lair	of Facility neral Home Road Kings	sville, M		21087	
		ysician Medical aminer		23a. Part 1. Enter the disease, or conshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	. ^ ^		a. Do not ent	er the mode	of dying. - 	such as cardiac	or respiratory a	irrest,		Approximate Interval Between Onset and Death
		miner	-		· Core	as a consequence of the conseque		Act	ور	D:	Selos	e		
	68760, C	physicien and is the burial-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	as a consequ								
	P.O. Box 60	To the Funerel Director: After this certificate has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use as	Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	23c. If yes, outcom 1 Live birth 4 Pregnant 9 Unknown	2 Fetal	death 3	Ectopic preg Other (spec				23d.	Date of delive	ery Day Year
	rds, P	n signed h	þ	Part Other significant conditions	contributing to death	but not resu	ulting in the u	nderlying cau	ise giver	n in Part I.		tobacco use d Yes 2 □ N		the cause of death?
	Division of Vital Records, to Attending Physicien: The law requires tatler death.	icete has bee	Completed		-ibrille	sit e	ν <b>ν</b>				24a. Was auto perfe 1 Yes		Ib. Were auto prior to co death? 1 ☐ Yes	opsy findings available ompletion of cause of
	f Vita	is certif directo	To Be	25. Was case referred to medical examiner?  1  Yes 2	Hospital: 1  Inpa	tient 2	ER/Outpatier	nt 3□ DOA	Other	26. Place of Dear			Other (Specif	(v)
	ON O	: After the funeral		27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of In (Month, E	ijury Day Year)	28b. Time o Injury	M 280	Unjury a Work?		28d. Describe			
	Division Attents after dea	I Director of in by the	Certification:	3 Suicide 6 Could not to determined	289. Place of I	njury - At ho etc. <i>(Specif</i> y	me, farm, str	eet, factory, o	office		281. Location ( City or To	(Street and Nu wn, State)	ımber or Rura	al Route Number,
	he Hospite n 24 hours	he Funere	edical	29a. Certifier (Griock Griff) one)  Certifying P Z   Medical Exa	hysician: To the besinifier: On the basis and manner	or examinar	wledge, deat	n occurred at vestigation, in	the time	n, date and place, nion, death occur	and due to the	cause(s) and date and place	manner as s ce, and due to	tated. o the cause(s)
4	To t	Comp	Σ	29b. Signature and telepof certifier	_			29c. 1	License	number 5346 Z	_	29d. Date sig	gned (Month,	Day, Year)
		1		30. Name and address of person who	completed cause of	death (Item	23a) (Type.						•	
	0.00	9 Sta	-	31. Date filed (Month, Day, Year)	<b>№</b> ?*	845 strar's Signa	DAY ture	mood	R	ond G	Spanga	rnie	Um,	21061
		Registra		MAR 1 5 200	32. Regis	100	A STATE OF THE PARTY OF THE PAR							

hysiciar		State     Registrar  1. Decedent's Name (First, Middle, Last)			Certificat	e of D	eath	2. Date of De	Reg. No. ath	Year	3. Time of Deat
/Medica Examine	al -	Henry Clay Stewar 4a. Facility Name (If not institution, give s Ellicott City Hea	treet and number)	bilita	4b. City,	Town, or l	ocation of D	March eath ity	9, 20		
neral ector	ı	5. Social Security Number 6. Sex 410-44-9895 Usual Residence of Decedent 10a. State 10b. County	M 2□F	74  Oc. City, Town	rs. Months		Hours A	Hrs. 8. Date of Bir (Month, Da		Co	nplace (State or Fore untry)  Tennessee  10d. Inside City Lim
28a-f aho	ctor		ward		10f. Zip		cott City		10g. Citize	n of What Co	1 ☐ Yes 2X
must be	<u>a</u>	7050 Ducketts Lane #10	12. Was Decedent Eve	or in U.S.	13. Was Dece	dent of His	2107	(Specify Yes or No Jerto Rican, etc.)	- 14	. Race - Ame	
Examiner	2	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	Amed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Oates:		If Yes, spe		, Mexican, P	uerto Rican, etc.)		Black, White	White
ill tem 27 is marked other than "natural", or items 23s or 28s-f show or other treumstic event, the Madical Examiner must be notified at	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	cation e completed) College (1-4or 5+)	16a.	Decedent's Usu (Give kind of wo life. DO NOT u	ork done du se retired)	ion iring most of Iscaping	working	16b. Kind	of Business/Land:	scaping
itic event,	To Be C	17. Father's Name (First, Middle, Last)  Henry Cla	ıy Stewart					Name (First, Middle	Maiden Si Cora Fa		
m 27 Is ma her treuma		19a. Informant's Name/Relationship (Type Mr. Charles Morris	Grandchile	d		ıcketts		r Rural Route Numb 01 Elkridge, N Date	aryland	21075	
Importent: If Ite any Injury or ot once.		20a. Method of Disposition  1 □ Burial 2 □ Cremation 3 □ R  4 □ Donation 5 □ Other (Specify)		cemeter	Bavview Cr	ematon	/	03/10/2006	20c. Loca	ition - City or i	ore, MD
ysicie e bu	icai Examiner	disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a co	onsequence o	rf):			acia(ar	<i>y</i> () e	y 13 C	
se as		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown	3c. If yes, outcome of p 1 Live birth 2 4 Pregnant at tim 9 Unknown	Fetal death	3 □Ectopic p 5 □ Other (s <sub>i</sub>				23	d. Date of deli Month	very Day Year
y the atter	<u>-</u>	Part II. Other significant conditions con	tributing to death but n	ot resulting in	the underlying	cause giver	n in Part I.		Yes 2	No 3 ☐ Pro	the cause of death
ate hes been signe	Completed by	OF Weep and a series of the se						1 ☐ Yes	osy rmed? 22 No	death?	2 No
certificate hes rector, page 2	To Be Completed by	25. Was case referred to medical examiner? 1 □ Yes 2 □ No  27. Manner of Death 1 □ Natural 5 □ Pending 2 □ Accident investigation	lospital: 1 ☐ Inpatient 28a. Date of Injury (Month, Day Yo	2 ☐ ER/Out 28b. T ear) Ir		Other 28c. Injury Work	4⊠Nursin	- auto	osy omed? 25 No one dence 6 [	death? 1 ☐ Yes  ☐ Other (Spec	2 □ No
certificate hes rector, page 2	To Be Completed by	examiner? 1 □ Yes 2 □ No  27. Manner of Death 1 ☑ Natural 5 □ Pending	28a. Date of Injury	ear) 28b. T	ime of ijury M	Other  Other  Other  Other  Other  Other  Other  Other  Other	48 Nursin	autor performance of the perform	one)  dence 6 [  Street and i	death? 1  Yes  Other (Spec	2 □ No
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he Funeral Director: After this certificate has plately filled in by the funeral director, page 2	Medical Certification: To Be Completed by	examiner?  1	28a. Date of Injury (Month, Day Young) 28e. Place of Injury building, etc. (sician: To the best of mer: On the basis of exand manner stated	28b. T In At home, far Specify)	m, street, factor death occurred for investigation	OA Other 28c. Injury Work: 1 Y  y, office at the time n, in my opi	4⊠Nursin at es 2 □ No a, date and p nion, death c	autopendo 1	one dence 6 [  Street and in win, State)  cause(s) are and p	death? 1 Yes  Other (Special Concurred)  Number or Ru  and manner as lace, and due signed (Month)	2 □ No  ral Route Number,  stated. to the cause(s)

			1- State of Maryland State of Maryland		ment of H			giene 006	07914
	Physici	ian	Decedent's Name (First, Middle, Last)		-		2. Date of Dea Month		3. Time of Death
	/Medi	cal	Ronald Singleton  4a. Facility Name (If not institution, give street and number)	4	h City Town or	Location of Oeath	Marci	4c. County of De	7:35FM
	Examir Funeral	ier	Franklin Square Hospita	1	Rose f Under 1 Year	edale If Under 24 Hrs.		Balt	imore
	Director		5. Social Security Number 6. Sex 7. Age   In yrs. la		onths Days	Hours Min.	(Month, Day March	8,1946Wa	nthplace (State or Foreign lountry) Shington, D
	land ow		Usual Residence of Decedent         10a. State         10b. County         10c. City	, Town or Locati	ion				10d. Inside City Limits
	Mary I-f sho	tor	MD Baltimore Mid	dle Ri	ver				1 ☐ Yes 2 ☐ No
-()	or 28a-f	Olrec	10e. Street and Number		10f. Zip Code			10g. Citizen of What C	ountry?
/	a 23a	rail	41 Chelmsford Ct.		21220			U.S.A.	
Q "	r Item	by Funeral Director	11. Marital Status  12. Was Decedent Ever in U.S Armed Forces?  1 □ Never Married 2 □ Married  1 □ X S Decedent Ever in U.S	If Ye		spanic Origin? (Si n, Mexican, Puerti	pecify Yes or No- p Rican, etc.)		ite, etc.
<u></u>	n 72 hours after deeth with the Maryland "natural", or Itema 23a or 28a-f show gdical Examinat must be notified at	d by	X□Widowed 4□Divorced If Yes, Give Year or Date Vietn	am 10	Yes 2⊠ No	Specify:		Specify: W1	nite
15-0	72	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Decedent	t's Usual Occupa d of work done d	tion uring most of wor	king	16b. Kind of Business	s/Industry
212		E O	Elementary/Secondary (0-12) College (1-4or 5+)		e Sale		1	H & S Bal	kery
Maryland 2	be filed withintal Hygiene.	Be C	17. Father's Name (First, Middle, Last)			18. Mother's Nam	e (First, Middle,	Maiden Surname)	
yla	2 should be and Mental is marked o	2	Robert Melvin Singleton					heridan	
Na A	s 1 and 2 should f Health and Men Item 27 is marke other traumatic		19a. Informant's Name/Relationship (Type, Print)					r, City or Town, State,	, ,
J 5	to the alth the man to the tree to the tree tree tree tree tree tree tree			ace of Dispositio			Date	more, MD 20c. Location - City o	
OC.	permit. Pages Depertment of Important: If it any injury or one		4 Denation 5 Other (Secretal	view C	remato	rv   3-1	5-06	Baltimore	MD.
3alt	Depertit. Depertimport		21. Signature of Funeral Service Licensee	22. Na	ame and Address	s of Facility Bra	dley-A	shton Fu	neral Home
0	40240		23a. Part1. Enter the disease, or complications that caused the death.	P .	A., 21	<u>34 Will</u>	ow Spr	ing Rd.,	21222 Approximate
//	Physician		snock, or heart failure. List only one cause on each line.  Immediate Cause (Final	DO HOT BIRD!		Cardiac		est,	Interval Between Onset and Death
	/Medical		disease or condition resulting in death)  Due to (ocus a consequence)	ence of):	leart	TON	UPE		
	Examiner	_	Sequentially list conditions, b.						
N	nslt	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	ance of):					
, o	executen and rial-tran		that initiated events c	ence of);					
8760,	cate be executed obysicien and the burial-transit	dicai	d						
9		/Med	IF FEMALE: 23c. If yes, outcome of pregnan	ncv		· · · · · · · · · · · · · · · · · · ·			
Bo	death e atter d for u	Iclar	in the past 12 months?  1 Vas 2 No 4 Pregnant at time of dea	death 3□Ect	topic pregnancy her (specify)			23d. Date of de Month	Day Year
P.0	thet the death the by the atter deteched for u	Phys	9 ☐ Unknown						
Division of Vital Records, P.O. Box	8 20 8	Completed by Physician/Me	Part II. Other significant conditions contributing to death but not resul	ting in the under	rlying cause giver	n in Part I.	23e. Did toi	bacco use contribute t es 2 □ No 3 □ P	o the cause of death?
000	law requir as been si 2 should l	plet					24a. Was a		utopsy findings available
<u>~</u>	The cete h	Соп					autops perform	med? death?	completion of cause of
Vita	sician certifi rector	Be	25. Was case referred to medical examiner?		Other	26. Place of Deat			
o	y Phya er this eral di	n: To	27. Manner of Death 28a. Date of Injury 2	28b. Time of	28c. Injury	4 🗆 Nursing no		ence 6 Other (Spe	icify)
ion	anding ath. or: Aft	atlo	2 Accident Investigation	Injury		es 2 No			
ivis	or Atte	Certification;	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At hom building, etc. (Specify)	ne, farm, street,	factory, office		28f. Location (St City or Town	treet and Number or R n, State)	ural Route Number,
۵	spital ours e neral E		29a. Certifier 1 Certifying Physicien: To the best of my know	dedne death oc	curred at the time	date and place	and due to the or	aa.(a) and	
	To the Hospital or Attending Physician: The law within 24 hours efter death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medical	(Check only one)  2   Medical Examiner: On the basis of examination and manner stated.	on and/or investi	igation, in my opi	nion, death occur	red at the time, d	ate and place, and du	e to the cause(s)
	To the within 2 To the complet	Σ	29b. Signature and title of certifier		29c. License			9d. Date signed (Mon	
	1		Maria mo			63 Ø54	(	March 1	3, 2006
	5	1	30. Name and address of person who completed cause of death (Item: Majid Cina, B544 Wheatfield We	23a) (Type, Prin	it) H- Cisho - M	ND 21	043		
	Sta		31. Date filed (Month, Day, Year) 32. Registrar's Signatu						
	Registr	वर 🕆	15 B D 1 F 2000 8	Mi A.	M .				

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 1:25 A M 2006 Garry Vince Todd March 7, /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Rockville Casey House Hospice If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months 187M 2□ F Director 58 406-70-7131 28,1948 Kentucky Feb. Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County or 28a-f show Examiner must be notified at MYes 2 No Directo Prince George's Bowie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Items 23a 20715 USA 14110 Lancaster Lane by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: "Unk" Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 ☐ Never Married 21X Married Baltimore, Maryland 21215-0036 'natural', or Specify: Black 1 ☐ Yes 2 🔀 No Specify: 3 ☐ Widowed 4 ☐ Divorced Completed the Medical 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) US Air Force Military or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be permit Pages 1 and 2 should be 1
Department of Health and Mental Inportant: If Hem 27 is marked oil any injury or other transcreen. James Edward Todd 2 Addie Spaulding 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Etennesh A. Todd/Wife 14110 Lancaster Lane, Bowie, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a Method of Disposition 1 🛣 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Greenwood Cemetery Mar. 11, 2006 Russellville, Kentucky 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Gamble Funeral Home, PO Box 1561 Hopkinsville, KY 42241 ennes Moncin 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Pancreatic Cancer /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of): The law requires that the death certificate be executed use as the burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of): ed by the attending physicien detached for use as the burial Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? Month Day 4 Pregnant at time of death 5 Other (specify) 1 Yes 2 No 9 Unknown s been signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? has page 2 autopsy performed? certificete 2 □ No 1 Yes 2X No 1 Ves ospital or Attending Physician: Thours after death.
uneral Director: After this certificet Physician: Certification; To Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 | Inpatient 1 ☐ Yes 2X No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 🗌 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Momicide within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a Certifier (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) nd title 29c. License number 29b. Signature D35635 March 8, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Joseph Kaplan, M.D. 6001 Muncaster Mill Rd., Rockville, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 17 Rev 1/2001

State Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Year Mary Alice Taylor 2006 9:23 March 10, /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Mariner Health Care Laurel Prince George 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours Days 1 ☐ M 2 🗓 F Director 215-44-3977 101 Dec 18, 1904 Maryland Usual Residence of Decedent Pages 1 and 2 should be tiled within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If Itam 27 ie marked other than "natural", or items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 17 is marked other than "natural, or items 23a or 28a-f show traumatic event, the Mudical Examinar must be notified at Director 1 Tes 2 XNo Prince George Beltsville 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 10428 43rd Avenue 20705 Completed by Funeral U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 🕅 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 9 Home maker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be George T. Sellers Bertha M. Seibel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Eldon E. Taylor /son 10428 43rd Avenue, Beltsville, Maryland 20705 permit. Pages 1 and Department of Healti Important: if itam 27 any injury or other tonce. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Lincoln Cem. Mar 14, 06 Brentwood, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Donaldson Funeral Home, P.A. M00773 | 313 Talbott Ave. Laurel, Maryland 20707-4389 23a. Part1. Enter the sease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or lie in tulure. List only one cause on each line. Approximate fnterval Betwe Immediate Cause Final disease or condition resulting in death) Onset and Death Physician Cerebral Thrombosis minutes /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, it any, is adding to immissible cause. Enter Underlying Cause (Disease or injury that infrated events Due to (or as a noneequence of): Examiner The law requires that the death certificate be executed use as the burial-transit signed by the attending physicien and resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 4 Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 🖾 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed? 1 Yes 2 🔀 No or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 X Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28b. Time of 28c. injury at Work? 28d. Describe how injury occurred After 1 X Natural 5 Pending investigation М 1 ☐ Yes 2 ☐ No 2 ☐ Accident completely filled in by the Director: 6 Could not be determined 3 Suicide 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours after To the Funeral Dire 1X Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and 29c. License number 0 address of person who completed cause of death (Item 23a) (Type, Print) William A. Warren, 321 Prince George St. Laurel, Maryland 20707 M.D. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAR 1 5 2006 Registrar

DHMH 17 Rev 1/2001

Registrar

ORIGINAL

2006

		_1	For State Registrar	State of Maryla	•	rtment of H			giene Reg. No. 006	07918
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Fun Dire			0.11 20 00 00 1			If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.		rth 9. Bi	nthplace (State or Foreign Quntry) Carolina
	sdical Extrainer cust	Completed by Funeral Director	Usual Residence of Decedent  10a. State 10b. County  MD None  10e. Street and Number  732 Lyndhurst St.  11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced  15. Decedent's Edice (Specify only highest grace)  Elementary/Secondary (0-12) 10	12. Was Decedent Ever in Armed Forces? 1 □ Yes 2 ☒ No If Yes, Give Year or Dates:	16a. Deced (Give i life. L		Specify: ation furing most of wor	rking	Specify: B 16b. Kind of Busines: Drinking Manufact	lerican Indian, ite, etc.  lack s/Industry Cup
ges 1 and 2 should be to fleath and Mental Hitem 27 is marked o	r traumatic	To Be	Arthur Roosevelt   19a. Informant's Name/Relationship (7) Marion Williams - 20a. Method of Disposition 1  Burial 2 Cremation 3   1  Donation 5 Other (Specify, 21. Signafure of Fineral Service Licens	Daughter  Removal from State  St	7432 Place of Disposementary, crem alling mily Ce	Cattericle ition (Name of natory or other place metery Name and Addres	Minnie and Number or Ru k Court,  3/11 s of Facility S	Hassel Gwynn ( Date /2006 mith Cor	per, City or Town, State,	1244 r Town, State
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D G G	CI	Completed by PI	Part II. Other significant conditions co Type I Deakel Chronic Obse	ntributing to death but not re	sulting in the un	derlying cause give	en in Part I.	1 🗆 24a. Was auto	s an 24b. Were a prior to death?	Probably 4 Unknown
VICIAN:	rector	To Be	1	28a. Date of Injury (Month, Day Year)	ER/Outpatient 28b. Time of Injury	28c. Injury Work M 1 \( \text{\text{Y}} \)	ar: 4 □ Nursing H	ath (Check only of dome 5 Resi 28d. Describe		
To the Hospital or Attanding Phys within 24 hours after death.  To the Funaral Diractor: After this	completely filled in b	ledical C	(Check only 2 Medical Exam	building, etc. (Special Special  nowledge, death	occurred at the timestigation, in my op	oinion, death occu	City or To	cause(s) and manner a date and place, and du	te to the cause(s)	
2	Sta		30, Name and address of person who of the state of the st	modules  ompleted cause of death (Ite  BEH, MD  32. Registrar's Sign	em 23a) (Type, I	O 149 Print) Down C BAITIM		mone	3/2/20 3/2007 +73	06
Re	gistra	-	MAR 1 5 2	000	As A	andel &				

			For State Registrar	State of Maryland		nt of Health te of Deat			ene g. No. 0 0 (	07919
	Physici /Medic	an	1. Decedent's Name (First, Middle, Las Kobert D	liegel Sr.			2	Date of Death Month	Day Ye	3. Time of Death
F.,	Examin Funeral Director	er	4a. Facility Name (If not institution, give	spital, 5001 Localle	avertful		er 24'Hrs. 8	2/239 Date of Birth (Month, Day, 7/02/19	4c. County of N/A N/A  Year) 9.	Birthplace (State or Foreign Country) Marvland
	ס	tor	Usual Residence of Decedent  10a. State 10b. County  MD N/A		Town or Location			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	10d. Inside City Limits
	h with the 23a or 28e at be noti	ai Director	10e. Street and Number 3601 Ailsa Ave.			ip Code 1214		10	g. Citizen of Wha	at Country?
920	be filed within 72 hours after death with the Maryland tal Hygiene.  Id Hygiene.  Id other than "natural", or liems 23e or 28e-f ahow event, its Medical Examiner must be notified at	by Funeral	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 □ No If Yes, Give Year or Dates: Korear	1 🗆 Vas	edent of Hispanic ( ecify Cuban, Mexic 2X No Speci		y Yes or No- can, etc.)		American Indian, White, etc. hite
21215-0036	within ane. than	Completed by	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12) 12	lucation de completed) Coltege (1-4or 5+)	16a. Decedent's Us (Give kind of w life. DO NOT Printe	rork done during m use retired) 		В		Engraving
Maryland	should be filed ind Mental Hygis is marked other umatic event, I.	To Be C	17. Father's Name (First, Middle, Last) William Wiegel			Sol	phie Ba	um	faiden Sumame)	
	1 and 2 s Health ar em 27 ls other trau		19a. Informant's Name/Relationship ( Mr. Robert Wiegel 20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □	, Jr./ Son	19b. Mailing Address 8440 Gar ce of Disposition (Notetory, crematory of	den Rd. I		ia, MD		
Baltimore,	permit. Pages Department of Importent: If it any injury or o		*4 Donation 5 Other (Specification 21. Signature of Funeral Service Licer	n ∣Gard	ens of Fa dson <sup>22. Name</sup> Leonar	ith cem. and Address of Fac d J. Rucl	cility	5305	altimore Marford? more, MD	Rd.
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rds, P	requires that the developers signed by the a hould be detached for	b	Part II. Other significant conditions of	contributing to death but not result	ting in the underlying	cause given in Pa	urt I.	1-1-		ute to the cause of death?
I Records	The law ate has b	Completed						24a. Was a autops perfort 1 \( \text{Yes} \)	y prio ned? dea VZNo 1 E	re autopsy findings available or to completion of cause of ath?  Yes 2 No
Vital	Physician: Th this certificate ral director, pag	To Be	25. Was case referred to medical examiner?	Hospital: Inpatient 2 E	R/Outpatient 3	Othor		Check only on 5 ☐ Reside	Mariano de a de la compansión de la com	(Specify)
Division of	fter fter	Certification: T	27. Manner of Death    Alatural   5   Pending   2   Accident   investigation   3   Suicide   6   Could not be	28a. Date of tnjury (Month, Day Year)	28b. Time of tnjury M	28c. Injury at Work?		d. Describe ho	w injury occurred	
Divi	To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu		4 Homicide determined	building, etc. (Specify)	vledge, death occum	ed at the time, date	and place, ar	City or Town	n, State) ause(s) and manr	ner as stated.
7)	ne Hos n 24 ho ne Fun pletely	edical	(Check only 2 Medical Exa	miner: On the basis of examination and manner stated.	on and/or investigati	on, in my opinion,	death occurred	d at the time, di	ate and place, an	d due to the cause(s)
	To the within To the comp	Me	29b. Signature and titlenof certifier	fee fils	2	29c. License numb	er 09	2	9d. Date signed (	Month, Day, Year)
	17		30. Name and address of person who Lawrence Mills,	Ir. Ms, Good	Lamentan	Hospital,	560i Lo	chlare	n Blod, &	altimore, Md 2123
	St	ate	31. Date filed (Month, Day, Year)	32. Pegistrar's Signati	ure la Amerik	E				/

				1 - For State Registrar	State of M		l / Depa		of He	ealth and	Mental F		e	6 (	79	20
				1. Decedent's Name (First, Middle, Las	st)						2. Date of Month	Death	av	Year	3. Time	of Death
		Physici /Medic		Jean Wittm	yer						MARCH	1 10	2 0	200%	18:3	30 PM
		Examin	_	4a. Facility Name (If not institution, give	,	7)		4b. City, T	own, or	Location of De	ath	4	c. County	of Death		
	187	3.			DSPITAL					HORE If Under 24 H	len la n	Di di				
	2.0	Funeral		5. Social Security Number 6. S 213-12-0787	ex 7.A □M 21XTF	ge (In yrs. Ia 78	st birthday) Yrs.	If Under 1 Months	Days	Hours Mi	in. (Month,					e or Foreign
	it.	Director		Usuel Residence of Decedent							June	10,1	121	M	aryla	ilia
		yiano how		10a. State 10b. County		10c. City,	Town or Lo	cation						1		City Limits
		e Mar	ctor	Maryland Balti	more		Ca	tonsv								es 2 No
		permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heelth and Mental Hygiene. Important: if Item 27 ie marked other than "naturel", or Iteme 23a or 28a-f show any injury or other treumatic event, the Marical Examinating the ricities and page.	Director	10e. Street and Number 221 Osborne Av	onuo			10f. Zip (	Code 1228			10g. C	USA	What Cour	itry?	
		eath ve 23,	Funeral	11. Marital Status	12. Was Deceden	t Ever in U.S	3. 13. \			spanic Origin?	(Specify Yes or	No-		e - Americ	an Indian	
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	2	filed Hygie ther ther tont,	ပိ	17. Father's Name (First, Middle, Last,	)		11	Omema		18. Mother's N	Name (First, Mic	dle, Maide				
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	Baltimore, Maryland 21215-0036	shou and M mar	1	19a. Informant's Name/Relationship (							Rural Route Nu					210/2
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	ore	t of He		20a. Method of Disposition  1 Burial 2X Cremation 3	Removal from State	e ce	metery, crer	natory or oth	her place		Date			City or To		
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				23a. Part1. Enter the disease, or comshock, or was failure. List only	plications that cause	ed the death.	Do not ent	630 E	dmon	dson A	ve. Cate	onsvi y arrest,	11e,	Mary	1and Approxim	21228 nate
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8		siciar certif irecto	o Be	25. Was case referred to medical examiner?  1 Yes 2 No	Hospital: 1 Inpa	tiont 2 0	ER/Outpatier	nt 3□ DO	Othe		Death <i>Check</i> of g Home 5 ☐ F		e 🗆 🗀	or /Speci	4.1	
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4		To To		* K Ran	nem	MD		-	PI	7/02	•	100	ionil	7/9	20	06
		11:		30. Name and address of person who	completed cause of	f death (Item	23a) (Type,	Print)	/ /	1602	YORE, M	1.07	LH	100	au	
		10		KULLI RAMES	H 9.0	0 5	CATON	/ AVE	:	BALTIA	YORE M	Da	1122	9		
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		1 - For State Registrar	State of Ma	aryland / Depa <i>Cei</i>	artment of H		Mental Hy	giene Reg. No.	06 0	7921
		1. Decedent's Name (First, Midd	die, Last)				2. Date of De		Year	3. Time of Death
Phys /Me	iciar dica	7	zabeth Willia	emmee .			Februa	-		2:30A M
Exar		An Contline Manne of the Contline of			4b. City, Town, or	Location of De			ounty of Death	
		Shady Grove Ad			Rockv	ille If Under 24 H	rc   a B   i B		Montgor	
Funer		5. Social Security Number	6. Sex 7. Ag	e (In yrs. last birthday) Yrs.	If Under 1 Year Months Days	Hours Mi	n. (Month, Da	ay, Year)	Coul	
Direct	or	200-09-0955 Usual Residence of Decedent		93 <sup>trs.</sup>		l	June 3	,1912	Penn	sylvania
yland	9	10a. State 10b. Count	ty	10c. City, Town or Lo	cation					Od. Inside City Limits
B Mar		Ternessee Rhea	a		Davton					1 ☐ Yes 2 ☐ No
deeth with the Maryland ms 23a or 28a-f ehow	1	Terrnessee Rhea			10f. Zip Code			10g. Citize	n of What Cou	ntry?
eth w 8 238	9			- 110	3732		/O		ed Stat	
lten de		191 Log Town F  11. Marital Status  1 Never Married 2 Ma	12. Was Decedent Armed Forces? 1 ☐ Yes 2 ☑		Was Decedent of Hi If Yes, specify Cuba	ispanic Origin? in, Mexican, Pu	erto Rican, etc.)	5- 14	Race - Americ Black, White,	
J36 Jrs aff		3 Widowed 4 □ Divorce	If Yes, Give		1∐ Yes 2X No	Specify:		S	pecify:Whit	e
2 hou		15. Decede	ent's Education lest grade completed)	16a. Dece	dent's Usual Occup	ation	norkina.	16b. Kind	of Business/In	dustry
'1215-0036 within 72 hours after ene. then "natural", or Ite the Modical Exemina		15. Decede (Specify only high Elementary/Secondary (0-12)		)+)	kind of work done of DO NOT use retired	()	iorning .			
filed w Hygier other th	8			Ho	omemaker	40 Markeda N	/Fina Adiddia		wn Home	<u> </u>
Maryland 21215-UU36 Id 2 should be filed within 72 hours af th and Mental Hygiene. 27 le marked other then "natural", or traumatic event, the Madical Exem	٥	17. Father's Name (First, Middle				18. Mothers N	lame (First, Middle			
re, Maryland 21215-0036  1 and 2 should be filed within 72 hours after deeth with the Marylan Health and Mental Hygiene. I Health and Mental Hygiene. Item 27 le marked other then "natural", or Items 23a or 28a-f show other traumatic event, tra Midical Examinar matal be maillied at	16	Oliver S. McCl		19b. Mailir	ng Address (Street a	and Number or	Ella Mae			Code)
t, Ma and 2 s ealth ar n 27 le					241 3	8 6 8		or outside the	500	
of Health item 27		Sylvia McManus 20a. Method of Disposition		20b. Place of Dispo	sition (Name of matory or other place		ayton, Ti	20c. Loca	tion - City or To	own, State
Pages Pages nent of int: If it		1 ∑Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other	n 3 □Removal from State (Specify)	Buttram C			.25,2006	Dayto	on, Ten	nessee
Baltimore, permit. Pages 1 ar Depertment of Hea Importent: If item eny Injury or othe	ġ	21. Statistice of Faral Anyo	Licensee	22	2. Name and Addres	ss of Facility	Vanderwa	all Fu	neral H	Iome
n gaes	а	- Samoly Sile	Wille	M01113 Hv	vy. 27, P.	O. Box	148, Dayt	on, T	ennesse	e 37321
		23a. Part1. Enter the disease, shock, or heart failure. Lis	or complications that caused st only one cause on each lie	I the death. Do not ent ne.	er the mode of dyin	g, such as card	iac or respiratory a	rrest,		Approximate Interval Between Onset and Death
Physicia		Immediate Cause (Final disease or condition resulting in death)	_a_ Sepsis	5						5 Days
/Medic Examin		resulting in Geattry	Due to (or as	a consequence of):						
		Sequentially list conditions, if any, leading to immediate	b. Due to (or as	a consequence of):						
Head ansit	1 1	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	1							
760, 100 to be executed ysicien and e burial-transit			Due to (or as	a consequence of):						
I HECOrds, P.O. BOX 68/60, —— The law requires that the deeth certificate be executed ate has been signed by the attending physicien and page 2 should be detached for use es the burial-transit	100	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑No 9 □ Unknown  Part II. Other significant conditions	d					_		
e es t	13	F FEMALE:							1	
Geeth certific e attending pod for use es	1	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 ☐Live birth 4 ☐ Pregnant at	2 Fetal death 3	Ectopic pregnancy			23	<li>d. Date of deliver Month</li>	ery Day Year
IS, P.O. I fres that the de- signed by the a I be detached f	19	1 □ Yes 2 X No 9 □ Unknown	9☐ Unknown	time of death 5	Other (specify)			-		
that the led by the detache	d	Part II. Other significant condi	tions contributing to death b	ut not resulting in the u	nderlying cause give	en in Part I.	23e. Did	tobacco use	contribute to t	he cause of death?
rds quires n sign							10	Yes 2 🛚	No 3□Prot	oably 4 Unknown
VITAI HECONGS, sicien: The law requires t certilicate has been signe rector, page 2 should be c		<u> </u>					24a. Was		24b. Were auto	psy findings available
He fav		Dietec					- auto perfe 1  Yes	ormed?	death?	mpletion of cause of
	6	25. Was case referred to medic examiner?	al	=0		26. Place of D	eath (Check only			A
		O 1 ☐ Yes 2 ☐ No	Hospital: 1 Inpatie			4 🗀 Muranig	Home 5 ☐ Res			ý)
On O ding P Ih. After I	į	27. Manner of Death  1 Natural 5 Pend		y Year) 28b. Time of Injury	Work		28d. Describe	how injury o	occurred	
DIVISION Of VITA  or Attending Physician: after death. Director: After this certification by the funeral director,	1	2 Accident inves		ury - At home, farm, str		Yes 2 □No	28f Location (	Street and I	Number or Run	al Route Number,
DIVISION SPITED OF ATTENDOUS AFTER GOTT PROPERTY (FILLING TO FILLING 1	27. Manner of Death  1 Natural  2 Accident inves  3 Suicide 6 Coule  4 Homicide deter	building, et		eet, ractory, onlos			wn, State)	1011001 01 1101	ir riodio riumbor,	
DIVISIC  To the Hospitel or Attend within 24 hours after death To the Funerel Director: completely filled in by the	1   2		ring Physician: To the best	of my knowledge, deat	h occurred at the tin	ne, date and pla	ce, and due to the	cause(s) ar	nd manner as s	tated.
To the Hos within 24 h To the Fur completely		one)	at Exeminer: On the basis of and manner sta	r examination and/or in	vestigation, in my of	pinion, death oc	curred at the time,	, date and p	lace, and due to	o the cause(s)
Vith To To	2	29b. Signature and title of certif	ier M		29c. License	_			signed (Month,	_
		र वर्रा	i FID			163		4:	22/2	
10		30. Name and address of person Hakim Morsli,	·			rille N	MD 300E0			
	State	21 Date filed (Month Day Vee	ir) 32. Registr	ar's Signature	ROCK	ATTTE' L	עני עני			
	istra		006	ar's Signature						

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** MARCH 2006 ĭŏ John Frew Wallace 3:20 AM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner GREATER BALTIMORE MEDICAL CENTER TOWSON BALTIMORE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea 4-19-1923 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Funeral Days Hours 1 ☑ M 2 ☐ F 82 193-12-0634 Pennsylvania Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. Counts 10c. City, Town or Location r then "naturel", or Itema 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Towson MD Baltimore Direct 10g. Citizen of What Country? 10f. Zip Code 21204 10e. Street and Number 728 Camberly Circle Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Specify: white 1 ☐ Yes 2X No Specify: ģ 3 ☐ Widowed 4X Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) le marked other then Elementary/Secondary (0-12) College (1-4or 5+) Key Personnel Employer 12 or other traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 end 2 should be file Depertment of Health and Mental Hy Important: If Item 27 is marked oth any jury or other traumatic event 2008. Be Veronica Wolman William Alfred Wallace 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
7 Manor Brook Monkton Rd., MD 21111 19a. Informant's Name/Relationship (Type, Print) Fred Nickerson/Personal Rep 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition t Burial 2 ☑ Cremation 3 ☐ Removal from State 3-11-2006 West Arundel Crematory Odenton, MD 4 □ Defiation 5 □ Other (Specify) Ambrose Funeral Home, Inc. 1328 Sulphur Spring Rd. Arbutus MD 21227 Sign Ture of Funeral Service Approximate Interval Between Otset and Death 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) PNEUMONIA **Physician** /Medical Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last CONGESTUE HEART FAILURE or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, ettending physician for use as the buria Certification: To Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Perobably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed? 1 ☐ Yes 2₽No : After this certifice e funeral director, p 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Impatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: All completely filled in by the fu 2 Accident 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide o the Hospital 29a. Certifier 1 54-Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signaturi and (i) f or rtifier D0061519 M.D. Mu Name and address of prison who completed cause of death (Item 23a) (Type, Print) AJANI 126 OLIVER HEIGHTS RD, OWNERS MILLS, MDZING 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year 14:39 PM **Physician** RAMONA MARC 2006 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner NA BALTIMORE CIT THE JOHNS HOPKINS HOSPITAL 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplece (State or Foreign Country) **Funeral** Months Days Hours Min. 1 ☐ M 2 💢 F Yrs. 213-30-1248 73 Director Md Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location items 23a or 28e-f ehow the Medical Examiner must be notified at XXYes 2 □ No Md. NA Baltimore Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1023 N. Kenwood Avenue 21205 USA Funerai 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married "neturel", or Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: Black δ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12th grade Housekeeping Varies 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Depertment of Heelth and Mental Hy Important: if Item 27 is marked oth eny fulury or other traumatic event pose. Milton Chase Sarah Lane 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1023 N. Kenwood Ave., Baltimore, Md. Rhonda Wright Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 3-15-06 King Mem. Park Randallstown, Baltimore, Md. 2120 1101 E. North Ave. 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 21202 March F.H. East My Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) PANCREATITIS **Physician** 2 WEEKS /Medical Due to (or as a consequence of) Examiner 5YEARS END STAGE LIVER DISEASE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner The law requires that the death certificate be executed ettending physicien and for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 9 Unknown 3 DEctopic pregnancy Month Day Year 4 Pregnant at time of death signed by the eight be detached for 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed? 1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 X No page 2 certificete director Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 1 ☐ Yes 2 ER/Outpatient 3 DOA this After this funeral o 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 28b. Time of Certification: 1 Natural 2 Accident 5 Pending M 1 ☐ Yes 2 ☐ No investigation within 24 hours efter deal To the Funeral Director: 6 Could not be determined 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation in my opicion, death occurred. 29a. Certifier Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier M.D. March 10,2006. 3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Molte Caltimore North 600 MOHUN RAMRATNAM 31. Date filed (Month: Day, Year) 32. Redistrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene - State Registra Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Marcela Zegada 103y Physician 2005ar 4:12a м /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Casey House Rockville Montgomery If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, **Funeral** Months Days Hours 1 ☐ M 2 🖺 F 577-64-7814 Yrs 07-14-1918 Bolivia Director Usual Residence of Decedent with the Maryland 10c. City. Town or Location 10d. Inside City Limits 10a, State 10b. County r than "naturel", or Items 23a or 28a-f ehow the Medical Examinar must be notified at 1 TYes 2X No Rockville MDMontgomery Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11608 Split Rail Ct. 20852 USA 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11 Marital Status permit. Pages 1 and 2 should be filed within 72 hours after 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel", or iter any injury or other traumatic event, the Medical Examinat 1 ☐ Yes 2√ No If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☑ Yes 2 ☐ No Specify: Bolivian White ₽ P 3 ☐ Widowed 4 ☑ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Homemaker Own Home 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Demetrio Jordan Natividad Santa Cruz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11608 Split Rail Ct. Rockville MD 20852 Maria Blanton/daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 TCremation 3 ☐ Removal from State 03-14-2006 Chesapeake Crematory Beltsville MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Fineral & 21. Signature of Funeral Service L Rapp Funeral & Cremation Service 933 Gist Av Silver Spring MD 20910 Stiple Johnmann Mc0382 Approximate Interval Between Onset and Death 23a. Part1. Emer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Cerebrovascular Accident /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, I any, leading to min adiatacause. Enter Underlying Cause (Disease or injury Que to (or as a donsequance of) signed by the attending physicien and d be detached for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Day Month Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ▼ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2√No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an this certificate has autopsy performe 1 Yes 2 X No or Attending Physician: After this certific funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 1 ☐ Yes 2 ☐XNo 1 Inpatient 2 ER/Outpatient 3□ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 XXX ther (Specify)HOSpice Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending Natural 2 Accident within 24 hours after death.

To the Funerel Director: All completely filled in by the fu М 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospitel 29a. Certifier 1 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and itle of certifier 03-13-2006 D35635 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Joseph Kaplan MD 6001 Muncaster Mill Rd. Rockville MD 20855 32 Registrar's Signature 31. Date filed (Month, Day, Year) State

Registrar

MAR 1 5 2006

32 Registrar's Signature

porte

			For State Registrar			nd / Depa		of Health	and M	ental Hyg		06	792	5
			1. Decedent's Name (First, Middle							2. Date of Deat Month			3. Time of D	Death
	Physici /Medic		Carolyn June							Februar	y 26,		6:20	Рм
	Examin	er	4a. Facility Name (If not institution Genesis Elderc			enter		vn, or Location nnapoli				nty of Death Anne A	rundol	
	Funeral		5. Social Security Number	6. Sex		. last birthday)	If Under 1 Y	ear If Unde		8. Date of Birth			lace (State or	Foreign
	Director		231-24-0243	1□M 2፟XF	79	Yrs.	Months Da	ays Hours	Min.	8. Date of Birth (Month, Day, June 12	, 192	6 Vi	rginia	
	w w		Usual Residence of Decedent  10a. State 10b. County		10c. C	ity, Town or Lo	ocation					1	Od. Inside City	/ Limits
	Maryli f sho	tor	Maryland Calv	ert		,,		Dunkir	k				1 ☐ Yes	
	h the	lrec	10e. Street and Number				10f. Zip Co			1	0g. Citizen	of What Cour	ntry?	
	within 72 hours after death with the Maryland one. then "natural", or items 23e or 28e-f show the Medical Exam. or must be confilled at	by Funeral Director	4012 Lakeview	Turn				2075				S.A.		
	er de sitams	une	11. Marital Status	Armed F	edent Ever in torces?	J.S. 13.	Was Decedent If Yes, specify	of Hispanic O Cuban, Mexica	rigin? (Spe ın, Puerto F	cify Yes or No- Rican, etc.)		Race - Americ Black, White,		
936	urs aft	by F	1 ☐ Never Married 2 ☐ Marri 3 ☐ Widowed 4XXXDivorced	ed 1 □ Yes If Yes, Gi Year or D	Ve		1 □ Yes 2 <b>○</b>	No Specify	:		Spe	cify: Wh:	ite	
21215-0036	72 ho	Completed	15. Decedent (Specify only highes			16a. Dece	dent's Usual O	ccupation	st of workin	na	16b. Kind o	f Business/Inc	dustry	
121	within ne. han "	mpl	Elementary/Secondary (0-12)	College (	1-4or 5+)	life.	DO NOT use re	etired)				_	,	
2	filed v Hygie othar t	e Co	17. Father's Name (First, Middle, I	Last)	·	AC	countar		er's Name	(First, Middle, M			ealersh	пр
<u>lan</u>	Aental Aental rked c	To Be	Alfred Lynch					Ina	Pugh	ı				
Maryland	12 sho h and h 7 la ma trauma	·	19a. Informant's Name/Relations Brenda M. Rob		uahter					n Route Number, Tunkirk,	-		Code) 20754	
	t Healt tram 2		20a. Method of Disposition		20b.	Place of Dispo						on - City or To		
E O	Page nent o ant: If ury or		1 ☐ Burial 2 <b>∑</b> Cremation `4 ☐ Donation 5 ☐ Other (S <sub>i</sub>		State	Line		I	3/2	/2006	Brent	wood, 1	Marylan	ıd
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23s or 28s-f show any injury or other traumatic avent. Its Medical Exam act must be confilted at once.		21. Signature of Funeral Service I	Licensee						M. Tay ter St.				401
			23a. Part1. Enter the disease, or	complications that	caused the dea							фотть	Approximate Interval Between	
	Pnysician		shock, or heart failure. List of Immediate Cause (Final disease or condition	only one cause on	aci ine.	Pn	eum	v					Oriser and De	
	/Medical Examiner		resulting in death)	Due to	(or as a conse								/	
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to	(or as a conse	quence of):								-
	ate be executed hysician and the burial-transit	Examiner	that initiated events resulting in death) Last	c.										
60,	be exician a	Ical Ex	roodiling in doubly 2250	Due to	(or as a conse	quence or):								
68760,	ificate g phys as the		<del></del>	d										
Box	death certifics e attending ph ed for use as t	an/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, ou	tcome of pregr	nancy aldeath 3	Ectopic pregn	ancv				Date of delive		
0		Physician/Med	in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown		nant at time of		Other (specify	y)				Month	Day Ye	9ar
Δ.	law requires that the as been signed by th 2 should be detache	by Ph	Part II. Other significant condition	ns contributing to d	eath but not re	sulting in the u	nderlying cause	e given in Part	l.	23e. Did tob	acco use c	ontribute to th	ne cause of de	ath?
ords	w require been sig should b	ed b								1 □ Ye	s 2 A	3 □ Prob	ably 4 □Un	iknown
Records,	has be	Completed								24a. Was ar autops perform	v	b. Were auto prior to cor death?	psy findings av	railable use of
	Th ate pag	e Co	25. Was case referred to medical							1 ☐ Yes 2	□ <b>Z</b> No		2□ No	
of Vital	Physiclan: r this certific ral director,	To Be	examiner?	Hospital:	Inpatient 2	ER/Outpatien	it 3□ DOA	Othor		(Check only only only only only only only only		Other (Specifi	()	
0 0	ng Ph fter th ineral	L:uo	27. Manner of Death Natural 5 ☐ Pending	28a. Date (Mon	of Injury th, Day Year)	28b. Time of Injury	28c.	Injury at Work?	2	8d. Describe ho	w injury occ	curred		
Division	uttandi death. ctor: A y the fu	icat	2 Accident investig	ot be 200 Bloom	of laium. At i	nome form et-		1 ☐ Yes 2 ☐	-	28f. Location (St	root and Nu	mbos as Rum	/ Pouto Alumb	0.5
Δ	al or A safter il Direc ed in by	Certification;	4 ☐ Homicide determi	ned 286. Flact build	of Injury - At I ing, etc. (Spec	ify)	eet, ractory, on	rice		City or Town		IIID <del>o</del> i Oi Auia	I HOULE NUMBE	57,
	To the Hospital or Attanding Phys within 24 hours after death.  To the Funaral Director: After this completely filled in by the funeral di	edical (	29a. Certifier (Check only one)  1 Certifying 2 Medical E	g Physician: To the examiner: On the b	e best of my kn easis of examin ner stated.	owledge, death ation and/or in	n occurred at the	ne time, date a my opinion, de	nd place, a ath occurre	and due to the ca ad at the time, da	use(s) and ate and plac	manner as st e, and due to	ated. the cause(s)	
)	To the within To the comp	M	29b. Signature and title of certifier	Mary (	S		29c. Lio	Dense number	036	29	od. Date sig	ned (Month,	Day, Year)	
			30. Name and address of person v	who completed cau	se of death (Ite	m 23a) (Type,	Print)	Kinco	C	berter,	Mi	1211	. / C	
	Sta		31. Date filed (Month, Day, Year)	32 6	gistrar's Sign	ature	/ 2				-		41/	
	Registr	ar	FEB 2 8	2006		15 14	Second !							

			For State of M  State of M Registrar	aryland / Dep	ertificate of			iene •g. No. 006	07926
F	Physici		1. Decedent's Name (First, Middle, Last)  Terrie Lee Andrews				2. Date of Deat Month Februar	Day Year	
	/Medic Examin	raes	4a. Facility Name (If not institution, give street and number) Calmra Princess Gardens		Lanham	or Location of Death		4c. County of Dea	ath
	Funeral Director		220-70-5611 1□M 2XF	e (In yrs. last birthday 48 Yrs.	Months Days		8. Date of Birth (Month, Day, 02/25/1		rthplace (State or Foreign country) cyland
	the Maryland 28a-1 ehow	Director	Usual Residence of Decedent  10a. State 10b. County  Maryland Prince George 's  10e. Street and Number	10c. City, Town or L	Location 10f. Zip Code		1	Og. Citizen of What C	10d. Inside City Limits 1 \( \frac{\text{Y}}{\text{Y}} \text{Yes} 2 \( \frac{\text{No}}{\text{No}} \)
USb	be filed within 72 hours after death with the Maryland ital Hygiene. do do do then "ratural", or teme 23s or 28s-f show event, the Maulical Exetriner must be notified at	by Funeral	6120 Princess Garden Parkv  11. Marital Status  11. Marital Status  12. Was Decedent Armed Forces'  1	Ever in U.S. 13	. Was Decedent of I	Hispanic Origin? (Sp ban, Mexican, Pueric Specify:	ecify Yes or No-	USA  14. Race - Am Black, Wh  Specify:	erican Indian,
9500-61212	od within 72 hor giene. er then "naturi	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or	(Giv	DO NOT use retire	during most of worked)	king	16b. Kind of Busines:	
Maryiand	9 7 5	To Be (	17. Father's Name (First, Middle, Last)  Donald H. Andrews  19a. Informant's Name/Relationship (Type, Print)	10h Mai	line Address (Street	Kathlee	n M. McF		Zia Codo)
d)	l and 2 Health a m 27 li her tra		Donald Andrews/ Father  20a. Method of Disposition  1 Burial 2XX remailion 3 Removal from State	8203		Abbey Roa	d Glenn	Dale, MD 2 20c. Location - City o	20769
Baitimore,	permit. Pages: Department of H Importent: If Ite any injury or of		4 □ Donation 5 □ Other (Specify)  21. Signature of Euneral Septice Licensee		22. Name and Addr	ess of Facility Ro	bert E.	Waldorf, M Evans Fune , MD 20715	eral Home
,09/	Physician /Medical Examiner  the price-transit	Ilcal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	ne.		MERS (S	_		Approximate Interval Between Onset and Death
O. Box 68	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ ₹6 9 □ Unknown  23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Fetal death 3	□Ectopic pregnanc □ Other (specify) _	Ey .		23d. Date of do	elivery Day Year
1	quires that i en signed by uid be deta	þ	Part II. Other significant conditions contributing to death I	out not resulting in the	underlying cause gi	ven in Part I.			to the cause of death?  Probably 4 Unknown
al Reco	iiclan: The law requ certificate has been rector, page 2 shouk	e Completed	25. Was case referred to medical			00 River of Dec	24a. Was a autops perform	rior to med? death? 2☑No 1☐Ye	
Division of Vital Records,	ttanding Phys death. :tor: After this r the funeral di	Certification; To Be	examiner?  1  Yes 2 No Hospital: 1 Inpati  27. Manner of Death 1  Matural 5 Pending investigation 2  Accident investigation 3 Suicide 6 Could not be determined.	28b. Time Injury	of 28c. Inju	her: 4 Nursing Herry at ork?  Yes 2 No	28d. Describe ho	ence 6 Mother (Sp ow injury occurred	TOME
á	To the Hospital or A within 24 hours after To the Funeral Direc completely filled in by	lical	29a. Certifier  (Check only one)  29a Medical Examiner: On the basis and manners and manners.	of examination and/or-	investigation, in my	opinion, death occur	rred at the time, d	ause(s) and manner a ate and place, and du	ie to the cause(s)
)	To the within ? To the comple	Mec	29b. Signature and title of certifier  Therefore I Hags - C  30. Name and address of person who completed cause of II 700 TB c TS ULL 66  31. Date filed (Month, Day, Year)  MAR 0 1 2006  32 Agist	Lupius	29c. Licen	se number	2	9d. Date signed (Mor	nth, Day, Year)  3 27, Zext
	Sta		30. Name and address of person who completed cause of 11700 TB (LTS ULL) 631. Date filed (Month, Day, Year) 32 Asoist	death (Item 23a) (Type Pruv & rar's Signatu	e, Print) Fran	Teine A.S LTSULLE	nyman,	20705	
2	Registr	ar	MAR 0 1 2006	w to the	green !				

State of Maryland / Department of Health and Mental Hygiene 06

		•	1 - For State Registrar		Ce	rtificate of l	Death	Reg	j. No.	
	Discostation of the last		1. Decedent's Name (First, Middle,	Last)				Date of Death     Month	Day Ye	3. Time of Death
	Physici /Medic		Keith	Anthony	Ado	olphus		February		
1 .	Examin		4a. Facility Name (If not institution,				Location of Death		4c. County of E	
			7908 Pavillion			Severn	If Under 24 Hrs.			Arundel
1	Funeral Director		5. Social Security Number  559-37-9979  Usual Residence of Decedent	1 <b>M</b> M 2□ E	e (In yrs. last birthday 8 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, Y Aug. 18,	(ear)	Birthplace (State or Foreign Country) Belize
	show		10a. State 10b. County		10c. City, Town or L	ocation.				10d. Inside City Limits
	Mary First	to	MD Anne	Arundel	Sever	n				1 ☐ Yes 2 🛣 No
	r 28a	Director	10e. Street and Number			10f. Zip Code		100	g. Citizen of Wha	t Country?
	h wift	D E	7908 Pavillion	Drive		21	144		USA	
	deaf	ner	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S. 13.	. Was Decedent of H	lispanic Origin? (Span, Mexican, Pueno	ecify Yes or No- Rican, etc.)		American Indian, Vhite, etc.
21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Menfal Hygiene. If item 27 is marked other than "natural", or iteme 23e or 28e-f show or other traumatic event, it a Medical Exartinar must be rigitlisd at	by Funeral	1 Never Married 2X Marrie 3 Widowed 4 Divorced			1 ☐ Yes 2 <b>K</b> No	Specify:		Specify:	Black
5-0	72 h	etec	15. Decedent's (Specify only highest		(Giv	edent's Usual Occup e kind of work done	during most of work	ing 16	6b. Kind of Busin	ess/Industry
121	12 should be filed within h and Menfal Hygiene. 7 Is marked other than "traumatic event, tra Mes	Completed	Elementary/Secondary (0-12)	College (1-4or 5	+)	DO NOT use retired	•		T C A	
2	lled v Hygie Ther t		17. Father's Name (First, Middle, L	3	Star	f Sergeant		e (First, Middle, Ma	J.S. Arm	У
anc	nfal h	Be						d Reneau		
7	hould d Me mark marlo	2	Daniel Middlete		19h Mail	ling Address (Street			City or Town Sta	te. Zin Code)
Maryland	d 2 s th an traur		Hayde Adolphus			8 Pavillio				
a)	1 an Heal Iem 2		20a. Method of Disposition	(	20b. Place of Disp	osition (Name of	! !		Oc. Location - City	
<u>o</u>	ages ant of it: If it		1XXBurial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp	3 Removal from State	-	Vet. Cem		2006	Crownsvi	11 <sub>0</sub> MD
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If item 27 Is any injury or other trau		21. Signature of Funeral Service L			22. Name and Addre	ss of Facility			iie, iii
B	Depar Important in any ir		175- J.	-A		Hardesty	Funeral Ly Avenue	Home, P.A	A. lis. MD	21401
1			23a. Part1. Enter the disease, or on shock, or heart failure. List of	complications that caused	the death. Do not er					Approximate Interval Between
	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	a. ALS	a consequence of):	olesias	ophic !	Luteval	Scleve	
	n =	ner	if any, leading to immediate cause. Enter Underlying	Due to ( r as	consequence of):					
	ficate be executed physicien and ts the burial-fransit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	c	Sec zur	Y- Y				
Ó,	e exe ien a urial-		resulting in death) Last	Due to (or as	a consequence of);					
68760,	ate b hysic the b	Medical		d						
9 ×	= 0.10	Mec	IF FEMALE:	22a If yas outcome	of programs:					
.O. Box	The law requires that the death certificate be executed ate has been signed by the attending physicien and page 2 should be detached for use as the burial-fransit	Completed by Physician	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant at	2 Fetal death 3	☐ Ectopic pregnancy ☐ Other (specify)	/		23d. Date of Month	fdelivery Day Year
Δ.	that ff	P	Part II. Other significant condition	ns contributing to death b	ut not resulting in the	underlying cause giv	en in Part I.	23e. Did toba	acco use contribu	te to the cause of death?
ds,	signe d be	d by	HIB ADRMA	. 1		, ,		1 ☐ Yes	2 □ No 3[	Probably 4 Unknown
, Ö	v requ been shoul	ete	ale cens					24a. Was an	24h Wer	e autopsy findings available
Rec	has be 2	Ę						autopsy	ed? prio	r to completion of cause of the
a		ပိ	25. Was case referred to medical	14			00 Blace of Book	1 Yes 2		Yes 2 □ No
₹	Physician: r fhis certificanal director.	o Be	examiner?	Hospital: 1 ☐ Inpatie	nt 2□ER/Outpatie	ent 3 DOA Oth		th (Check only one) ome 5 Residen		(Spacific)
of	Phy r fhis	. To	27. Manner of Death	28a. Date of Inju		of 28c. Injur		28d. Describe hov		Specify
Division of Vital Records,	Attending in death.	tion	Natural 5 Pending 2 Accident investig		y Ye <i>ar)</i> Injury		rk?  Yes 2 🗆 No			
/isi	Atter dea actor	ifica	3 ☐ Suicide 6 ☐ Could n	ned 286. Place of In	ury - At home, farm, s	street, factory, office				or Rural Route Number,
Ö	at or s affe il Dire	Certification:	4  Homicide	building, et	с. (Ѕреспу)			City or Town,	State)	
	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director.	edical C	(Check only one)	Physician: To the best examiner: On the basis o and manner st	examination and/or	ally occurred at the tw investigation, in my c	ne, date and plane, ppinion, death occur	and due to the rail red at the time, dai	te and place, and	of 35 Mated. I due to the cause(s)
	withir To th	Me	29b. Signature and title of certifier			29c. Licens	se number	29	d. Date signed (A	Month, Day, Year)
			Par le 4	world.	P.	D 28	507	2	24	2006
			30. Name and address of person	completed use of c	eath (Item 23a) (Type		U K. 40	NKOFF	40	
			10 N. Gr	ceive ST		Truent	ues	D. 2	1201	
10	Sta		31. Date filed (Month, Day, Year)	32. Registr	ar's Signature	South				
40-2	Regist	ar	MAR 0	1 2006		1				

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** February 11, Lula Mae Jackson Anderson 2006 6:45 P.M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 2119 Ellis Street Silver Spring Montgomery If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours Min. 1 ☐ M 2**K** F 578-42-9511 Director 74 Yrs. December 8, Maryland Usual Residence of Decedent r 28e-f ehow 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1XYes 2 □ No Director Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ral', or Items 23a or Exactiner must be Ellis Street 2119 20910 United States Be Completed by Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 21215-0036 1 ☐ Yes 2X No Specify: Specify: Black 3 XWidowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 9 Housekeeper Supervisor 10th grade General Maintenance Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 2 should be fi and Mental F permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 is marked any injury or other traumatic everage. Harold Jackson Mary Dorothy Carter 2 19a. Informant's Name/Relationship (Type, Print) (Daughter) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 418 Oglethorpe Street, N.E.; Washington, D.C. 20011 Denise Lorraine Buchanan Baltimore, 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State Feb. 18,2006 cemetery, crematory or other place) 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) National Harmony Memorial Park Landover, Maryland 21. Signature of Funeral Sery . N. Horton Company Morticians, Inc. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 600 Kennedy Street, N.W.; Washington, D.C. <u> 20011</u> Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Atherosclerotic Heart Disease /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Box 68760. Completed by Physician/Medical the phy use as IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ō in the past 12 months?
1 Yes 2 No Month Dav Year 4 Pregnant at time of death 5 Other (specify) been signed by the should be detached o 9 Unknown 9 Unknown ۵ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Diabetes Mellitus, Hypertension; 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Chronic Renal Insufficiency; Dementia Anemia 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 2**X** No certificete 1 Yes 2 🗆 No 1 🗆 Yes of Vital or Attending Physician: 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home SXXResidence 6 Other (Specify) 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this erei Director: After th 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Injury at Work? Division 5 Pending investigation after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital o within 24 hours aff To the Funerel Di completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) February 17, 2006 Elwa, MD42936 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Elwin G. Bustos, M.D.; 1160 Varnum Street, N.E.; Suite 213; Washington, D. C. 20017 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAR 0 3 2006 Registrar

DHMH 17 Rev 1/2001

OPICINAL

		1 - For State Registrar Amend I	State of Ma tem I perd	rce5464217	rtment of I 7,06dhb tificate of	lealth and Death	Mental Hyg	iene () () 6 og. No.	0/325
Physi	ician	Decedent's Name (First, Middle, Last	t)				Date of Death     Month	h Day Yea	3. Time of Death
_	dical	Helen <b>Whipp</b>		ubaker			March	1 200	6 7:45 A M
Exam	niner	4a. Facility Name (If not institution, give	street and number)		4b. City, Town, o	or Location of Dea	ith	4c. County of De	eath
		143 Willowdale D			Frede			Frederi	
Funera	al	5. Social Security Number 6. So	x 7. Age	(In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs Hours Min		Year) 9. B	Birthplace (State or Foreign Country)
Directo	or	220-28-2860	IM ZIZIF	73 Yrs.			November	8, 1932	Maryland
Pue ≱ ∷		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or Lo	eation				10d. Inside City Limits
lanyla •ho	ក								1 Yes 2 □ No
he N	Director	Maryland Frede	rick		Frede	rick			
th with t 23a or 2	ai Dir	10e. Street and Number 143 Willowdale	Orive		10f. Zip Code <b>217</b> (	02	10	U.S.A.	Country?
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental hygiene. Important: If item 27 ie marked other then "natural", or items 23a or 28a-f show eny injury or other traumatic event, the Medical Examinar must be notified at	by Funeral	11. Marital Status  1 Never Married 2 Married	12. Was Decedent E Armed Forces? 1 Tyes 2 No.	0	Was Decedent of H f Yes, specify Cub 1 ☐ Yes 2 ☑ No		Specify Yes or No- rto Rican, etc.)	14. Race - Ar Black, WI Specify:	merican Indian, hite, etc. white
Line in	D D	3	Year or Dates:	1 10 0					
7 2 region	Completed	15. Decedent's Ed (Specify only highest grad	de completed)	(Give	dent's Usual Occup kind of work done DO NOT use retire	during most of wo	orking	16b. Kind of Busines	ss/Industry
4 a a a a a	E	Etementary/Secondary (0-12)	College (1-4or 5-	-)	maker	u)		Own home	0
The state of the s	ပိ	12 17. Father's Name (First, Middle, Last)		Поше	IIIIIIIII	18 Mother's Na	ıme (First, Middle, N	107	<b>C</b>
Maryland 21215-0036 d 2 should be filed within 72 hours aft th and Mental Hygiene. It is marked other then "natural", or traumatic event, the Medical Exam	To Be	Harry R. Whipp					i Wertz	andon damamo,	
and house	1	19a. Informant's Name/Relationship (7	ype, Print)	19b. Mailir	ng Address (Street	and Number or A	Rural Route Number,	City or Town, State	, Zip Code)
and 2		Minda Hamilton -	daughter	188	Ashfield	Court,	Frederick,	Maryland	d 21702
of He		20a. Method of Disposition		20b. Place of Dispo	sition (Name of natory or other pla	ce)	Date 2	20c. Location - City	or Town, State
Page Page nent of nrt: If		1 ☐ Burial 2 ☑ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Hemoval from State	Frederick			-2006 1	rederick	, Maryland
Baltimore, permit. Pages 1 a Department of Hes Important: If item	á	21. Signalary of Funeral Service Cen	see 🔪 🕜	22	. Name and Addre	ss of Facility	Stauffer I	Funeral Ho	ome
W FEE		Sharpy (Un	ulle O.	llac 16	21 Opossi	ımtown P	ike. Frede	erick. Man	ryland 21702
		23a. Part1. Enter the disease, or comp	lications that caused	the death. Do not ent					Approximate
Dhysinis		shock, or heart failure. List only of Immediate Cause (Finat	one cause on each line	1 . 0	6. 0	1.1	10		Intervat Between Onset and Death
Physicia: /Medica		disease or condition resulting in death)	a. Due to (or as a	consequence of:	ative .	dono			1 years
Examine	er		540 (0, 43 4	consequence on.					
	ē	if any, leading to immediate cause. Enter Underlying	Due to (or as a	consequence of):					
nsit	Examiner	Cause (Disease or injury							
exect n and al-tra	Exa	that initiated events resulting in death) Last	Due to (or as a	consequence of):					
760 e be sicia			d						
68760, ificate be executed g physician and as the burial-transit	edical		<u> </u>						
Box (eath certing attending for use a		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of	f pregnancy				23d. Date of d	telivery
P.O. BOX thet the death cer ed by the attendin detached for use	C a	in the past 12 months?	1 ☐ Live birth 2 4 ☐ Pregnant at t		Ectopic pregnancy Other (specify)	y		Month	Day Year
Check the c	lys!	9 Unknown	9□ Unknown						
deta	by Physician/M	Part II. Other significant conditions co	entributing to death but	t not resulting in the u	nderlying cause giv	ren in Part I.	23e. Did tob	acco use contribute	to the cause of death?
Vision of Vital Records, P.O. Box Attending Physician: The law requires thet the death cent or death.  ector: After this certificate hes been signed by the attendine by the funeral director, page 2 should be detached for use	D.						1 □ Ye	s 2XNo 3□	Probably 4 Unknown
K rec	Completed						24a. Was ar	24h Ware	autopsy lindings available
Re la la la la la la la la la la la la la	ם						autopsy	prior to	o completion of cause of
DE :: 1.		05 140					1 ☐ Yes 2	<b>Ø</b> No 1 □ Y	es 2 No
Vit	Be	25. Was case referred to medical examiner?	Hospital:		. 20 DOA Ott		eath (Check only one		
Phys this	7	1 Yes 2 No	1 Inpatien	t 2 ER/Outpatier	I 3 DOA	4   Nursing I	Home 5 Resider		pecify)
Jing After funer	0	1 Natural 5 ☐ Pending	(Month, Day	Year) 28b. Time of Injury	Wo		28d. Describe no	w injury occurred	
Signature of the control of the cont	ca	2 Accident investigation 3 Suicide 6 Could not be	28e Place of toing	ry - At home, farm, str		Yes 2 No	291 Location (Str	not and Number or	Rural Route Number,
<b>&gt;</b> 5 € 5 ⊆	Certification:	4 Homicide determined	building, etc.	(Specify)	eet, factory, office		City or Town,	State)	nurar noute Number,
Division of Vital Records, To the Hospital or Attending Physician: The law requires within 24 hours after death. To the Funeral Director: After this certificate has been sign completely filled in by the funeral director, page 2 should be	Medical C	29a. Certifier 1 Certifying Ph. (Check only one)	ysician: To the best of iner: On the basis of and manner stat	examination and/or in	n occurred at the til vestigation, in my o	me, date and plac opinion, death occ	e, and due to the ca curred at the time, da	use(s) and manner te and place, and d	as stated. ue to the cause(s)
To the within 2 To the complex	Z	29b. Signature and titte of certifier			29c. Licens	e number	29	d. Date signed (Mo	nth, Day, Year)
⊢ ≯ ⊢ 8		1	AMD	>		4818	4 -	ZIIIA	
<i>C</i> 3		20 00	alata d	- th (than 22 : 7	Daison 1	1010	1	21110	0
4		30. Name and address of person who o	onipieted cause of de	·	-rint) 7th	street	Frederic	CK. MI	D21701
	State	31. Date liled (Month, Day, Year)	32. Registrar	) 00 / r's Signature	W	07.	1 - 0011	) v &	
	strar	MAR 0 3	2006		1				

			For State Registrar	State of Maryland		rtment of H			iene <sub>g. No.</sub> 006	07930
1	J. Op. 25		Decedent's Name (First, Middle, Last)					2. Date of Dea Month	th Day Yea	3. Time of Death
egt.	Physicia /Medic		Raymond Anthony Be	irne				Februar	y 25, 200	6 3:50 P <sup>M</sup>
	Examin		4a. Facility Name (If not institution, give st	reet and number)			Location of Death		4c. County of D	
			332 Colony Point P			Edgewat		a Day of Birth	Anne Ar	
	Funeral		5. Social Security Number 6. Sex 189-26-8093	7. Age (In yrs. Ia:	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day)	Year)	Birthplace (State or Foreign Country) nnsylvania
	Director		Usual Residence of Decedent	70				01/04/1	750 10	iiiisyivaiita
	yland now		10a. State 10b. County	10c. City,	Town or Lo	cation				10d. Inside City Limits
	a-f-e	ctor	Maryland Anne Arun	del Edge	water					1 ☐ Yes 2XXVo
	or 28	Dire	10e. Street and Number			10f. Zip Code			log. Citizen of What	Country?
	s 23a	by Funeral Director	332 Colony Point P		10.1	21037	Service Original (Co		USA	merican Indian,
	er de Itema	nue	11. Marital Starts	<ol> <li>Was Decedent Ever in U.S Armed Forces?</li> <li>1 ☐ Yes 2XXNo</li> </ol>	. 13. V	Yas Decedent of Hi Yes, specify Cuba	spanic Origin? (Sp n, Mexican, Puerto	Rican, etc.)		/hite, etc.
36	irs aff	by F	1 Never Married XXMarried 3 Widowed 4 Divorced	If Yes, Give Year or Dates:	1	☐ Yes XXNo	Specify:		Specify: W	hite
Ö	filed within 72 hours after death with the Maryland Hygiene ther then "natural", or Items 23a or 28a-f ehow ent, I'm Mudical Examinar munitor notified at		15. Decedent's Educa		16a. Deced	lent's Usual Occupa	ation during most of work	ina	16b. Kind of Busine	
218	e. en "r	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	life. L	OO NOT use retired	)		United St	
21	ygien yer th	S		4	Petro	oleum Eng			Federal G Maiden Sumame)	overnment
gug	be fill	Be	17. Father's Name (First, Middle, Last)	÷ 0				ıise Mat	_	
7	d Mer marke	ဥ	Anthony Raymond Be 19a. Informant's Name/Relationship (Typ)		19b. Mailin	g Address (Street a			r, City or Town, Stat	e, Zip Code)
Ma	nd 2 s lth an 27 ls		Irma Jane Beirne/						ter, MD 2	
ē,	f Heal		20a. Method of Disposition	20b. Pla	ace of Dispo	sition (Name of natory or other place		Date	20c. Location - City	or Town, State
Ë	Page sent o int: If		1 XBurial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	movar from State Sacr	ed Hea	art Catho Cemetery	lichand	1/2006	Bowie, MI	)
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural; or tiems 23a or 28a-f ehow any injury or other traumatic event, the Mudical Examination and the notified at ance.		21. Signature of Funeral Service Licenses		22	. Name and Addres	ss of Facility Rol			neral Home
<u>-</u>	20E 2 9		1-10						, MD 2071	
Р			23a. Part1. Enter the disease, or complic shock, or heart failure. List only one	ations that caused the death. cause on each line.	Do not ente	er the mode of dyin	g, such as cardiac	or respiratory ari	rest,	Approximate Interval Between Onset and Death
Y.	Physician		Immediate Cause (Final disease or condition resulting in death)	Preumonio						, week
	/Medical Examiner		1 Contains in country	Due to (or as a consequence of the source of	_	urcer				1 4000
		er	Sequentially list conditions, if any, leading to immediate	Due to (or as a sonesqui		wi cer				() Care
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events							
oʻ	cate be executed physician and the burial-transit		resulting in death) Last	Due to (or as a conseque	ence of):					
8760,	sate be	lical	d.							
9	entific ling p	Mec	IF FEMALE:	a Maria and an and an analysis						
Вох	death certificate e attending phys id for use as the	ian/	23b. Was decedent pregnant in the past 12 months?	c. If yes, outcome of pregnan  1 Live birth 2 Fetal ( 4 Pregnant at time of de	death 3	Ectopic pregnancy Other (specify)			23d. Date of Month	Day Year
o.		Physician/Medical	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9 Unknown	a.iii 5_	Ciries (apeciny)				
α.	ge g	by Pł	Part II. Other significant conditions cont	ributing to death but not resul	Iting in the u	nderlying cause giv	en in Part I.	23e. Did to	bacco use contribu	te to the cause of death?
rds	quires on sign uld be							1 🗆 Y	'es 2 □ No 3 □	Probably 4 Unknown
of Vital Records,	e law requir has been si je 2 should	Completed						24a. Was autop		e autopsy findings available to completion of cause of
æ	That are page	Eo						perfor	rmed2 deat	h? Yes 2□ No
/ita	Physician: this certific al director,	Be (	25. Was case referred to medical examiner?			100	26. Place of Dea			
5	Physi rthis c ral dire	ပို	1 195 2 NO	ospital: 1 Inpatient 2 E					lence 6 Other (	Specify)
on C	Ing Witer une	ion	27. Manny of Death  1	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Wor	yat k? Yes 2 □No	200. Describe II	low injury occurred	
Division	Attending r death.	fica	3 Suicide 6 Could not be	28e. Place of Injury - At hor building, etc. (Specify,	ne, farm, str			28f. Location (S	Street and Number of	r Rural Route Number,
<u>S</u>	after after I Dire	Certification;	4 Homicide	building, etc. (Specify)	)			City or Tow	m, State)	
	ne Hospital or Attendi 124 hours after death in Funeral Director; A letely filled in by the fi	edical C		ician: To the best of my know er: On the basis of examinati						
	To the Hos within 24 hd To the Fun completely	Medi	one)	and manner stated.						
	Viit To COn	Σ	29b. Signature and title of certifier	) . O . M A		29c. Licens	3809		29d. Date signed (A 2/27/	
,			7. auten h	plated source of the state of	00a) (T :=:		23001		-/ 4 1/	06
			30. Name and address of person who con L- Kreetw Doyle		-		, 22 S.	Geore.	St. Baltu	nove MD 21201
	* St	ate	31. Date filed (Month, Day, Year)	32. Resistrar's Signat			·		. /	
	Regist		FEB 2 8 20	006	K	South				

DHMH 17 Rev 1/2001

ORIGINAL

**ORIGINAL** 

Wilbur Holloway Burnette

ADH

			1 - For State Registrar	State of Marylan		artment of H rtificate of L		nd Mental F	lygiene Reg. No.	06	07932
	Physici	an	1. Decedent's Name (First, Middle, Last,					2. Date of Month	Day	Year	3. Time of Death
	/Medic	al	Virginia C.  4a. Facility Name (If not institution, give	Burnette		4b. City, Town, or	Location of I	ebr	<del></del>	nty of Death	061577 M
	Examin	er	Route 50 00 R		outh	Bow		Joan	Prin	,	ever's
	Funeral		5. Social Security Number 6. Sec	x 7. Age (In yrs.	last birthday)	If Under 1 Year Months Days	If Under 24	Hrs. 8. Date of Min. (Month,	Birth		ace (State or Foreign
	Director		578-44-9886	3M 2ØF 71	Yrs.	World S Days	110010	March	Day, Year) 2,1934	Virg	inia
	iand ow		10a. State 10b. County	10c. Cit	y, Town or Lo	cation				10	Od. Inside City Limits
	Mary a-fah	tor	MD Prince G	eorges Bo	wie						1A Yes 2 No
	or 284	Director	10e. Street and Number			10f. Zip Code			10g. Citizen	of What Coun	try?
	death with the Maryland ms 23a or 28a-f ahow		12101 Quick Fox L			20721			USA		
0	be filed within 72 hours after death with the Marylar ital Hygiene. Id other than "natural", or Itams 23a or 28a-f ahow avent, Its Modical Examinations.	Funeral	11. Marital Status 1 ☐ Never Married 2⊠ Married	12. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 ☒ No	1	Was Decedent of Hi f Yes, specify Cuba		n? (Specify Yes or Puerto Rican, etc.)		Race - America Black, White, e	etc.
200	filed within 72 hours after Hygiene. other then "natural", or Ita ant, the Modical Execution	d by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:			Specify:			city: Bla	
Ç	n 72 h	Completed	15. Decedent's Edu (Specify only highest grad		(Give	tent's Usual Occupa kind of work done of DO NOT use retired	durina most o	f working	16b. Kind of	f Business/Ind	lustry
7 7	s withi	отр	Elementary/Secondary (0-12)	College (1-4or 5+) 5+		eacher	,		Gov	ernmen	t
and,	i 2 should be filed within " n and Mental Hygiene. I is markad othar than " raumatic avant, It e Med	Be C	17. Father's Name (First, Middle, Last)					s Name (First, Mid	dle, Maiden Sum	iame)	
<u>ya</u>	ould by Ment	To I	Mayton Childs				Elva				
Mar	d 2 sh th and 7 Is m traum		19a. Informant's Name/Relationship (T)			ng Address (Street a					
a)	Heali Heali tam 2		Rochelle Harley/ 20a. Method of Disposition	20b. F	lace of Dispo	sition (Name of		Date Date		n - City or To	MD 20772 wn, State
Ē	Pages lent of nt: If i		1  Burial 2  Cremation 3  F '4 Donation 5  Other (Specify)	temoval from State		natory or other plac ion Cem.		/04/2006	Clint	on, Ma	rvland
palitimor	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 Is marked any injury or other traumatic as ance.		21. Signature of Fune di Service Licens			. Name and Addres			nkins Fu	neral	
	90 = 9					74 Landov				20785	
			23a. Part1. Enter the disease, or compl shock, or heart failure. List only or Immediate Cause (Final	ne cause on each line.							Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a. Motor Ve		Accido	enl in	th Mu	liple.	Minie	2-5
	Examiner		Commentative first and distance	Dag to (or as a corrisor	abrice or,						•
	pe #isi	niner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseq	uence of):						
,	cate be executed physician and the burial-transit	Examine	that initiated events resulting in death) Last	Due to (or as a conseq	uence of):						
00/0	ysician ne buri	dlcall	· ·	d							
Ò	artifica ing ph e as th	au i	IF FEMALE:								
מסמ	leath certific attending p	lan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregna 1□Live birth 2□Feta 4□Pregnant at time of d	Ideath 3□	Ectopic pregnancy Other (specify)				Date of deliver Month	ry Day Year
	the de	Physiclan/M	1 ☐ Yes 2 🖾 No 9 ☐ Unknown	9□ Unknown		J Other (specify)			_		
ν. Γ	The law requires that the death certificate be executed ate has been signed by the attending physician and age 2 should be detached for use as the burial-transit	by PI	Part II. Other significant conditions co.	ntributing to death but not res	ulting in the ur	nderlying cause give	en in Part I.				e cause of death?
coras,	w requir been si should I							_ 1	☐Yes 2 No	, 3 Proba	ably 4 Unknown
S S S	e law has b	Completed						24a. W	tas an 24 itopsy informed?_	b. Were autop prior to con death?	osy findings available inpletion of cause of
VIIal		e Col	35 Was ones referred to medical					1 □ Ye	s 22 No	1 Yes	2□ No
	ysician: is certific director,	o B	25. Was case referred to medical examined?  1 Yes 2 No	Hospital: 1   Inpatient 2	ER/Outpatien	t 3 DOA Othe	25	f Death <i>(Check on</i> ing Home 5 ☐ R		Sther (Specify	can
DIVISION OF	는 도표	n: T	27. Manner of Death 1  Natural 5 Pending	28a. Date of Injury (Month, Day Year)	28b. Time of	28c. Injury	at	28d. Descril	e how injury occ	curred Oa	
SIO	tandir eath. tor: Af the fu	catle	2 Accident investigation 3 Suicide 6 Could not be	Tebruary 25, 20	206 06	1 D	Yes 2 No	+1 CC	tor tr	cuiles.	STARCK
5	or At after of Dirac in by	ertification:	4 Homicide determined	28e. Place of Injury - At he building, etc. (Specif	ome, farm, stre	eet, factory, office		28t. Locatio City or	Town, State)	mber or Hural	Route Number +
	To the Hospital or Attanding F within 24 hours after death. To the Funeral Director: After completely filled in by the funer?	O	29a. Certifier 1☐ Certifying Phy	sician: To the best of my kno	wledge, death	occurred at the time	ne, date and p	place, and due to t	he cause(s) and	manner as sta	ated. MARY MACL
	To ths Ho within 24 To tha Fu completel	ledical	one)	ner: On the basis of examina and manner stated.	tion and/or inv	estigation, in my op	oinion, death	occurred at the tin	ie, date and plac	e, and due to	the cause(s)
	To To Con	×	29b. Signature and title of certifier	Sheete 00	2	29c. License			_	ned (Month, L	
2	(12)		30. Name and address of person who co	ompleted cause of death (Ita-	23a) /Tupe	Print)	-05 J	7+/	1 800	icy t	1, 2006
_	(,,,,		SALVAdor Sylv	smpleted cause of death (Item	tospi	tal Dr.	re	Clever	MAN	1/4NC	1
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Signa	ture	d'a		6	//		
	Registr	ai 💮	MAR 0 1 2006	Miller Jo	4500						

			For State Registrar	State of	Maryland /		tment of H			giene Reg. No.	6	07933
*	Physici	× an	1. Decedent's Name (First, Middle	le, Last)					2. Date of Dea Month	ath Day	Year	3. Time of Death
	/Medic		SAMUEL		BLACKMO				FEBRUAI			2:00 P M
	Examin	er	4a. Facility Name (If not institution MANOR CARE	n, give street and numb	<b>9e</b> r)	4	tb. City, Town, or CHEVY C	Location of Death	1		ty of Death	v.
- 80		-	5. Social Security Number	6. Sex 7.	Age (In yrs. last b	pirthdav)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birt	h	GOMER'	place (State or Foreign
	Funeral Director		244-20-0683	1 🔀 M 2 🗆 F	79	Yrs.	Months Days	Hours Min.	(Month, Da MARCH 1	y, Year) .3 1926	Cour	H CAROLINA
	D		Usual Residence of Decedent		1							
	arylar ehow	_	10a. State 10b. County		10c. City, To						1	10d. Inside City Limits 1 GyYes 2 ☐ No
	Ba-f	ecto		GOMERY	SILV	ER SE				10g. Citizen of	NA/Lat Cour	
	with t	Ö	10e. Street and Number	штоших	٠,٠٠٠		10f. Zip Code 20910					iti y r
	death with the Maryland ims 23a or 28a-f ehow r must be notified at	Funeral Director	1220 EAST WEST	12. Was Decede	# 808 ent Ever in U.S.	13. Wa		ispanic Origin? (Si n, Mexican, Puert	pecify Yes or No	U.S. 2	A • ace - Americ	can Indian,
0	after death w or Items 23a	ᇤ	1 Never Married 2 Mar	Armed Force	□No				o Rican, etc.)		ack, White,	
2-003p	ours a	d by	3 ₩ Widowed 4 Divorced	d If Yes, Give Year or Date	es:	1	]Yes 2√2 No	Specify:		Speci	ry:	BLACK
ה	filed within 72 hours after death with the Marylan Hygiene the than "natural", or Items 23a or 28a-1 show int, the Madical Examine must be notified at	Completed	15. Deceder (Specify only highe	nt's Education est grade completed)	16.	a. Deceder (Give kir	nt's Usual Occupa nd of work done of	ation during most of wor f)	king	16b. Kind of B	3usiness/In	dustry
7	withir ane. then	d m	Elementary/Secondary (0-12)	College (1-4	lor 5+)		CTION CH			COV	ERNME	יאירי
D D	Hyg Hyg ent.	0	17. Father's Name (First, Middle,	, Last)	Į .	بطن	CIION CII	18. Mother's Nan	ne (First, Middle,			TA T
<u>a</u>	id be fental rked c	To B	CHARLIE BLAC	CKMON				CORA J	ONES			
Maryiand	s 1 and 2 should be if Health and Mental item 27 is marked other traumatic ev		19a. Informant's Name/Relations			•	•			•		Code) 20910
	5 # 7 # F		IRENE B. OV	VENS/SISTER				HIGHWAY				G,MARYLAND
Baitimore,	Pages 1 and the source of the		20a. Method of Disposition 1   Burial 2 □ Cremation	3 Removal from St	ate cemet	ery, crema	ion (Name of tory or other plac	1	Date	20c. Location	- City or To	own, State
	tmen tant:		4 Donation 5 Other (S		HARM		EMETERY			LANDOV		
g	permit. Pages Department of I Important: If it eny injury or o		21. Signature of Funeral Service	Licensee			Name and Addres	OVER ROAD	B. JEN			L HOME 20785
- K			23a. Part1. Enter the disease, o	or complications that cau	used the death. Do						LETTE	Approximate
	Physician		shock, or heart failure. Lis Immediate Cause (Final	t only one cause on eac		£	2 00 kg	A	1 =	. \		Interval Between Onset and Death
	/Medical	ì	disease or condition resulting in death)	a. Due to (or	r as a consequence	e of):	Ci ith	liker	mora	1 = 11		
	Examiner		Sequentially list conditions,	b								
	ed sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or	ras a consequenc	e of):						
	be executed icien and burial-transit	xan	that initiated events resulting in death) Last	C. Due to (or	r as a consequence	e of);		<del></del>				
9/	rate be executed only sicien and the burial-transit	cai		d								
9	ntificat ng phy as th		IE FEMALE.									
ROX	eath certific attending p for use as f	an/h	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	1 Live birt	ome of pregnancy th 2 Fetal dea		ctopic pregnancy				ate of deliver	ery Day Year
o.	at the dea by the al tached fo	Physician/Med	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnar 9□Unknow	nt at time of death vn	5 🗆 C	Other (specify)					
1	res that the igned by be detact		Part II. Other significant condit	ions contributing to dea	th but not resulting	in the und	ertying cause give	en in Part I.	23e. Did t	obacco use cor	ntribute to t	the cause of death?
Division of Vital Records,	law requires that the death certificate as been signed by the attending phys 2 should be detached for use as the	d by							1 🗆 '	Yes 2□No	3 🗆 Proi	bably 4 🗷 Onknown
Ö	s been si	Completed							24a. Was	an 24b	. Were auto	opsy findings available
ž	The de h	E O							autor perfo	rmed?	death?	ompletion of cause of
<u>E</u>	ician: T certificat rector, p	Be C	25. Was case referred to medical examiner?	al				26. Place of Dea	ath (Check only o			
<u>&gt;</u>	hysic his ce	To	1 ☐ Yes 2 🛣 No	Hospital: 1 ☐ Inp		Outpatient		4 Jay Nursing F	lome 5 ☐ Resi			fy)
E C	ding Ph h. After th funeral	on:	27. Manner of Death 1 ☑Natural 5 ☐ Pendi	ing	Injury 28b Day Year)	. Time of Injury	28c. Injun Worl		28d. Describe	now injury occu	ırred	
200	Attending Physician: r death. sctor: After this certification in the funeral director, in	icat	3 Suicide 6 Could	tigation	of Injury - At home,	farm stree		Yes 2□No	28f. Location (	Street and Num	nber or Rur	al Route Number.
<u>≥</u>	P Sign	Certification:	4 Homicide deteri	mined 288. Flace o	g, etc. (Specify)	101111, 01100	n, raciory, cince		City or To			
	To the Hospital within 24 hours a To the Funeral is completely filled	Medicai C		ing Physician: To the bas Il Examiner: On the bas and manne	sis of examination a							
	vithin 2 To the Complet	Me	29b. Signature and title of certifi				29c. Licens			29d. Date sign	6	Day, Year)
							000	54566		2/2	1106	
2	_(10)		30. Name and address of person	who completed cause	of death (Item 23a	a) (Type, Pr	rint)		-			
36	Sta	ate	31. Date filed (Month, Day, Year		gistrar's Signature	Lobby	Road,	Swit 2	30 17	10 m 10	,17/	1276
200 S	Regist		MAR 0 1	2006	w K,	great	E)					

			1 - State of Mar Registrar	-	epartment of Ho Certificate of L			iene 6	07934
ť	Physici	an	Decedent's Name (First, Middle, Last)      Decedent's Name (First, Middle, Last)      Decedent's Name (First, Middle, Last)	-			2. Date of Dear	Day Year	3. Time of Death
	/Medic Examin	al	James Marley Bollinge  4a. Facility Name (If not institution, give street and number)	3 [	4b. City, Town, or	Location of Death	February	/ 27 2006 4c. County of Dea	
		, e-	409 Church St.		New Wi			Carro	oll
	Funeral Director		5. Social Security Number  215-32-2333  6. Sex 1 △ M 2 □ F	(In yrs. last birth	Months Days  (rs.	If Under 24 Hrs. Hours Min.	B. Date of Birth (Month, Day) Jan. 30	Year) Co	thplace (State or Foreign ountry) aryland
	land land		Usual Residence of Decedent           10a. State         10b. County         1	IOc. City, Town	or Location				10d. Inside City Limits
	Mary	ţŏ	Maryland Carroll		New Wind	sor			1. Yes 2 □ No
	or 286	Directo	10e. Street and Number		10f. Zip Code		1	0g. Citizen of What Co	ountry?
	e 23a	eral	409 Church St.  11 Marital Status  12. Was Decedent Ev	or in II S		776	porty Voc or No.	U.S.A	
0	ges 1 and 2 should be filed within 72 hours after death with the Maryland tof Health and Mental Hygiene. If Item 27 ie marked other then "naturel", or Iteme 23a or 28e-f ehow or other traumatic event, the Medical Examinar mant be notified at	by Funeral	11. Marital Status  1 □ Never Married 2 Married  3 □ Widowed 4 □ Divorced  12. Was Decedent Every Armed Forces?  1 □ Yes 2 Morried  15. Was Decedent Every Armed Forces?  1 □ Yes 2 Morried  16. Was Decedent Every Armed Forces?		13. Was Decedent of His If Yes, specify Cubar 1 ☐ Yes 2 X No		Rican, etc.)	Black, Whit	
3-003g	2 hour		15. Decedent's Education	16a.	Decedent's Usual Occupa	ition		16b. Kind of Business	
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7	fited within Hygiene. Other then "	e Cor	5 17. Father's Name (First, Middle, Last)		concrete w	Orker  18. Mother's Nam	e (First Middle I	vault con	npany
yland	12 should be fited w h and Mental Hygier 7 le marked other ti traumatic event, ID	To Be	Harry Vernon Bollinger				e Myerle		
ary	and Men le marke sumatic	-	19a. Informant's Name/Relationship (Type, Print)	19b.	Mailing Address (Street a	nd Number or Rur	al Route Number	, City or Town, State,	Zip Code)
e, B	l and 2 lealth im 27 in		Ruby M. Bollinger/wife		09 Church St Disposition (Name of			, MD 21776 20c. Location - City or	Town Clots
Sairimore	permit. Pages 1 and 2 Department of Health s Important: If Item 27 is any injury or other tra once.		20a. Method of Disposition  1  Burial 2 □ Cremation 3 □ Removal from State  4 □ Donation 5 □ Other (Specify)	cemetery	ul's Luth. (	em. 3/3/	′2006 l	Jniontown,	MD
Dail	permit. Depart Import any inj		21. Signature of Furieral Service Licenson Xarde	er	22. Name and Address			uneral Honor, MD 2177	
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	/Medical Examiner		resulting in death)  Due to (or as a descriptions)	consequence o	f):				
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	s that t ned by e detac	by Ph	Part II. Other significant conditions contributing to death but	not resulting in	the underlying cause give	n in Part I,	23e. Did tol	pacco use contribute to	o the cause of death?
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vital Records,	ding Physician: The law n h. After this certificate has be funeral director, page 2 sh	Completed					24a. Was a autops perform	y prior to death?	utopsy findings available completion of cause of
<u> </u>	cian: ertifica ector, j	Вес	25. Was case referred to medical examiner?			26. Place of Deat			
5	Physic this c	5.	1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient  27. Manng of Death 28a. Date of Injury	2 ER/Out	patient 3 DOA Other	4   Nursing no		ence 6 Other (Spe	icify)
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DIVISION	To the Hospital or Attending Physician: within 24 hours after death. To the Funerel Director: After this certifica completely filled in by the funeral director, I	ertification:	2 □ Cuiside 6 □ Could not be	r - At home, far (Specify)	m, street, factory, office		28f. Location (St City or Town	reet and Number or R n, State)	ural Route Number,
	Hospita 24 hours Funerel etely fille	edical C	29a. Certifier (Check only one)  1 Certifying Physician: To the best of examiner: On the basis of examiner and manner state	xamination and					
	To the within To the	Me	29b. Signature and title of certifier	0	29c. License		2	9d. Date signed (Mont	th, Day, Year)
	WITH		pu y	M	1000	59943	F	Epway.	28,2000.
	N. 8		30. Name and address of person who completed cause of dea	nerA	Type, Print)	507 ve	3 mins	fer MO	21157.
1000	Sta Registr		31. Date filed (Month, Day, Year)  MAR 0 1 2006	s Signature	boart ,			,	

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Physicia	an	1. Decedent's Name (First, Middle, L	,						2. Date of De Month	Da		ar	3. Time of	f Death
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Examin	er	Lorien Nursing 8		atior	ı Ctr		Mt. Air				Carr			
Funeral Director		006-20-1137	Sex 7. Age 1 ☐ M 25€ F	e (In yrs. 1	ast birthday) Yrs.	If Under Months	1 Year If Ur Days Hou	nder 24 Hrs. urs Min.	8. Date of Bir (Month, Da Aug 14	y, Year)			ace (State of try) ine	or Foreign
/land		Usuel Residence of Decedent  10a. State 10b. County		10c. City	/, Town or Lo	cation					<u></u>	10	Od. Inside C	ity Limits
e Man ta-fsh	ctor	Maryland Carr	roll				we	stmin	ster				1 ¥ Yes	2 🗆 No
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death ms 23	Funeral	11. Marital Status	12. Was Decedent B		S. 13. \	Nas Dece			pecify Yes or No o Rican, etc.)	-	14. Race -	Americ		
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permit. Departm Importe any inju		21. Sanature of Funeral Service Lic	MO1	191			nd Address of F		Mestmin	rbor ster	aw Fu	ner 211	al Hor	ne
1		23a. Par 1. Enter the disease, or co	mplications that caused by one cause on each lin	the death	n. Do not ente	er the mod	le of dying, such	h as cardiad	or respiratory a	rrest,			Approximat Interval Bet	ween
Physician		Immediate Cause (Final disease or condition	Pneumor	nia,									Onset and I	Death
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iclan: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:				100		th (Check only o		-			
Phys this	on: To	1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending	28a. Date of Injur (Month, Day	y	ER/Outpatien 28b. Time of Injury		OA Other: 4) 8c. Injury at Work?	Nursing H	ome 5 Resident			Specify		
To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director.	Certification:	2 Accident investigate 3 Suicide 6 Could not 4 Homicide determine	be 280 Place of Inju	ıry - At ho	me, farm, stre	eet, factor	1 Tes 2	2 🗆 No	28f. Location (S City or Tow			r Rural	Route Num	ber.
spitel c		29a. Certifier 1X Certifying F	Physician: To the best of	of my know	wiedge, death	occurred	at the time, date	e and place	, and due to the	cause(s)	and manne	r as sta	ited.	
he Ho in 24 h he Fur pletely	edical	(Check only 2 Medical Excorp)	eminer: On the basis of and manner sta	examinat	ion and/or inv	estigation	, in my opinion,	death occu	rred at the time,	date and	place, and	due to	he cause(s	)
Tot Withi	Σ	29b. Signature and title of centifier	- Kei	ll	UM.	D 296	D 547				e signed ( $N$			
W35		30. Name and address of person wh		eath (Item)	23a) (Type,	Print)								
		Allen Reilly M				enue,	D-1, F	reder:	ick, MD	2170	)1			
Sta Registr		FEB 2 (	32. Regigra		die die	hour	4.							

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	/Medic	al	4a. Facility Name (If not institution, give			Syrne		Town, or	Location o		160.20		. County of D		625	
	Examin	er	Montgomery Ge					ney				1	Montg	omery	Y	
- 5	Funeral Director		5. Social Security Number 6. Se 579-10-3614	TH 0575	ln yrs. last l	Yrs.	If Under Months	Days	If Under 2 Hours	24 Hrs. Min.	8. Date of Birt (Month, Day 6 / 26 /			Birthplace ( Country) ulton		_
	Maryland s-f show	tor	10a. State MD  10b. County Montgom		Oc. City, To			ng						1	side City I	
	th with the 23a or 28 INI be not	Funeral Director	10e. Street and Number 17206 Emerson D	rive			10f. Zip	209	05			10g. Cit	izen of What US			
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28e-f show mortant: if item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event. Ire Middical Exactions to unit be mullified at once.	by Funer	11. Marital Status  1 Never Married 2 A Married  3 Widowed 4 Divorced	12. Was Decedent Eve Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	er in U.S.	i	Vas Dece Yes, spe ☐ Yes		spanic Orig n, Mexican Specify:	gin? (Spe i, Puerto F	cify Yes or No- Rican, etc.)		14. Race - A Black, W Specify:	merican Inc /hite, etc. W.hi		
21215-0036	within 72 ho ane. then "natu	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	cation le completed) College (1-4or 5+)		a. Deced (Give F life. D	kind of wo OO NOT u	ork done d se retired	luring most	t of workin	g		ind of Busine nstru			
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lary	2 shot and h is ma		19a. Informant's Name/Relationship (T)		15		-		and Numbe	or Or Rurai	Route Numbe	r, City	or Town, Stat	e, Zip Code		
Baltimore, N	Pages 1 and lent of Health nt: If item 27		Ruth A.Burton/D  20a. Method of Disposition  1  Burial 2  Cremation 3  4  Onnation 5  Other (Specify)	Removal from State	20b. Place ceme Ches	of Dispos	ettion (Na	ma of	on [ m.2/2	D:	e Silv ate 6	20c. L	Spri ocation - City ltsvi	or Town, S	itate	05
Balti	permit. Departm Importa any inju		21. Signatur Funeral Service Livens	ZZ'		9	241	Col	umbia	a Bl	Fune:	lve		ing,	<u>Md20</u>	910
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8760,	eate be executed physician and the burial-transit the burial-transit	cal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a c												
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Vita	Physicien: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:				Oth	25		(Check only o					
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Division	tal or Attendi rs after death. al Director: A led in by the fu	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc.		farm, stre	eet, factor	y, office		2	8f. Location (2 City or Tou			r Rural Rou	te Numbe	τ,
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)		Me	29b. Signature and title of cepitier	+			29	D00	5569	4			eb. 27			
	3		30. Name and address of person who calok Mathur	ompleted cause of dea 4000 O	ith (Item 23: lney-	a) (Type, Lay	tons	svil	le R	d C	lney,	Md	20832			
	Sta Registi		31. Date filed (Month, Day, Year) MAR 01 2	006 32. Agistrar'	s Signature	1	and l	ő								

885Please Type or PHH In Black Indelible Ink. Assure All Copies Are Legible. amend 23a per Dr. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year Physician 2006 05:20AM /Medical 4b. City. Town, or Location of Deeth 4e Fecility Name (If not institution, give street end number) 4c. County of Deeth Examiner ADVENTIST HOSPITAL If Under 24 Hrs. If Under 1 Year 8. Date of Birth (Month, Dey, Yeer) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. lest birthday) **Funeral** Months Days Hours M 2□ F NONE 02 2006 Director Usuel Residence of Decedent filed within 72 hours aftar death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ahow. 7 is marked other than "natural", or flems 23a or 28a-f ahor traumatic event, the Madical Examiner must be notified at 1 Yes 2 □ No JONTGOMER ITHERSBURG, Director 10f. Zip Code 10e. Street end Number 10g. Citizen of What Country? USA DRIVE #30 20877 Funeral 12. Was Decedent Ever in U,S.
Armed Forces?
1 ☐ Yes 2 D No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 ☐ Married 1□ Yes 2 No Baltimore, Maryland 21215-0036 Specify: BLACK à 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry I Hygiene. Elementery/Secondary (0-12) College (1-4or 5+) INFANT 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental H Be should be OPER UREEN ٩ 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) Pages 1 and 2 item 27 is 304 GAITHERSBURG, MD ATHER QUOIA DRIVE # JOSEFH 7624 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition ö 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ò CYCLE injury 21. Signature of Funeral Stories Licenses 22. Name and Address of Facility 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Physician /Medical Immediate Cause (Final disease or condition resulting in death) Previable fetus Examiner Due to (or as a consequence of) Physician/Medical Examiner severe prematurity The law requires that the death certificate be axecuted the burial-transit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last and Due to (or es a consequence of): ed by the attanding physician detached for usa as the buria Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of) 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I signed by 1 Yes 2 No 3 Probably 4 Unknown <u>م</u> completaly filled in by the funeral director, page 2 should be 24b. Were autopsy findings available prior to completion of cause of death? Be Completed 24a. Wes en autopsy performed? cartificate has 2LING 1 ☐ Yes 2D No or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Yes 2 No 1 Inpatient Medicai Certification: To 2 ER/Outpatient 3□ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 27. Menger of Death 28b. Time of Injury 28d. Describe how injury occurred after death. Director; After the 1 XVatural 5 Pending 1 🗌 Yes 2 🗆 No 2 Accident investigation 3 🗌 Suicide 6 Could not be determined 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital of within 24 hours a To the Funeral D 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as steted.

2 Medical Examiner: On the basis of exemination end/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) 29a, Certifier (Check only one) and manner steted 29b. Signature end title of certifier 29c. License number 29d. Date signed (Month, Dey, Yeer) 02/02/2006

State Registrar

BERNSTE 9901 MEDICAL 2006

30. Neme and eddress of person who completed cause of deeth (Item 23e) (Type, Print)

32 Registrer's Signature

**ORIGINAL** 

**DHMH 16 Rev 6/95** 

			For State Registrar	State of Man		artment of F			ene 06	07938
	Physici /Medio Examir	cal	Decedent's Name (First, Middle, Last     A Facility Name (If not institution, give	Con	ger 161	101	r Location of Death		Day Year 8 0 6 4c. County'of Dea	3. Time of Death  1738 M
	Funeral Director		5. Social Security Number 6. Se 175–22–1328 Usual Residence of Decedent	7M 27% F	in yrs. last birthday 79 Yrs.	-	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y	ear) Co	hplace (State or Foreign buntry) nsylvania
	ne Maryland 8a-f show	Director	10a. State 10b. County MD Kent	10	Oc. City, Town or L	Ches	stertown			10d. Inside City Limits 1 XYes 2 □ No
	d within 72 hours after death with the Maryland jiene. Ir than "natural", or Items 23a or 28a-1 show It a Macitial Eva . It attriast be redified at	Funeral Dire	146 Heron Point  1.1. Marital Status	12. Was Decedent Eve Armed Forces?	er in U.S. 13.	Was Decedent of H	21620 lispanic Origin? (Sp an, Mexican, Puerto		USA  14. Race - Ame Black, Whit	nican Indian,
2-0036	"natural", or I	by	1 Never Married 2 Married 3 Widowed 4 Divorced  15. Decedent's Edu (Specify only highest grad	1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	16a. Dece	1 Yes 2 No edent's Usual Occup a kind of work done DO NOT use retired	Specify: ation during most of work	sing 16	Specify: Tobb. Kind of Business.	white
Maryland 21215-0036	를 찾 다 다	Be Completed	Elementary/Secondary (0-12) 11  17. Father's Name (First, Middle, Last)	College (1-4or 5+)	life.	homema	ker	e (First, Middle, Ma	own hor	ne
	nd 2 should alth and Mer 27 Is mark r traumatic	То	John McMahon  19a. Informant's Name/Relationship (T)  Donald Steinweg	гре, Print) SON					City or Town, State, 2	Zip Code)
Baltimore,	t. Pa rtmen rtant: vjury		20a. Method of Disposition  1 Surial 2 Cremation 3 4 Donation 5 Other (Specify)  21. Signature of Funeral Service Licens	Removal from State	20b. Place of Disp cemetery, cre Old Trini	osition (Name of omatory or other place ty Church	yard 3/4	Date 20 1/06 Ch	c. Location - City or nurch Cree	Town, State
Ba	Depa Impo any ir		23a. Part1. Enter the disease, or compshock, or heart failure. List only o	ications that caused the		700 Locus	t St., Ca	ambridge,		
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s, D	een sign	by	Part II. Other significant conditions co	ntributing to death but n	not resulting in the u	underlying cause giv	en in Part I.			the cause of death?
Vital Record	The law ate has b page 2 sl	e Completed	25. Was case referred to medical				26 Place of Death	24a. Was an autopsy performe 1 Yes 2X	prior to	topsy findings available completion of cause of
of	ding Phys n. After this funeral di	tion; To B	examiner?	lospital: 1 Inpatient 28a. Date of Injury (Month, Day Ye	2 ER/Outpatie 28b. Time o Injury	of 28c. Injury World	er: 4 🗆 Nursing Ho		e 6 Other (Specinjury occurred	eify)
Division	- 0 -	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury building, etc. (5	Specify)		1	City or Town, S		
	To the Hospital or Al within 24 hours after or To the Funeral Direct completely filled in by	Medical	29a. Certifier (Check only one)  1 ☐ Certifying Phy 2 ☐ Medicel Exami	sician: To the best of m ner: On the basis of ex- and manner stated	amination and/or ir	th occurred at the tin nvestigation, in my o	pinion, death occur	red at the time, date	se(s) and manner as and place, and due . Date signed (Monto	to the cause(s)
)			30. Name and address of person who ca	7 Good to the completed cause of death	h (Item 23a) (Type			1. 3 d 2162	-	
	s Sta	_	31. Date filed (Month, Day, Year)	516 Woshin 32. Registrar's	Signature	- Chata	town Me	d 2162	.0	
	Registr	ar	Divisi o o		no ser s					

			1 - For State Registrar	ate of Maryland		artment of		nd Mer		ene 9. No. 0 0 6	07939
	Physici		1. Decedent's Name (First, Middle, Last)  John Martine Co	urt					Date of Death Month arch		3. Time of Death 1:10 PM
ı	/Medio Examir		4a. Facility Name (If not institution, give stree	· ·		4b. City, Town,			arcn	4c. County of Dea	th
	Funeral Director		900 Cumberstone  5. Social Security Number  156-05-9463  1□XM	7. Age (In yrs. la		Harwoo If Under 1 Year Months Days	If Under 24	Min.	Date of Birth (Month, Day,		thplace (State or Foreign buntry)
	Aaryland F show	or	Usual Residence of Decedent  10a. State  10b. County  Maryland Anne Arunde		Town or Lo	cation					10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	with the Ne or 28e-	Direct	10e. Street and Number	I III W		10f. Zip Code				g. Citizen of What C	
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other then "neturel" or Items 23e or 28e-1 show appriancy or other treumetic event, the Marice Examined in the Conflict of DOCE.	by Funeral Director	1 □ Never Married 2 □ Married	/as Decedent Ever in U.S rmed Forces? DXYes 2 □ No Yes, Give 1932-19 ear or Dates	li li	20776 Vas Decedent of Yes, specify Cub	an, Mexican, I	in? (Specify Puerto Rica	Yes or No- an, etc.)	14. Race - Am Black, Whi	te, etc.
21215-0036	within 72 ho iene. then "netur ihe Medical	Completed	15. Decedent's Educatio (Specify only highest grade con Elementary/Secondary (0-12)	ollege (1-4or 5+)	16a. Deced (Give life. L	lent's Usual Occu kind of work done OO NOT use retire	pation during most o d)	of working		6b. Kind of Business	/Industry
Maryland 2	ould be filed Mental Hyg arked other etic event,	Be	17. Father's Name (First, Middle, Last) Alvah Breaker Court				Anita	Brook	rst, Middle, M Ks Mart	aiden Sumame) ine	
	and 2 sheatle and 2 1 sheatle and 27 ls metroum		19a. Informant's Name/Relationship (Type, F Sarah Court Rohrbach)			g Address <i>(Stree</i> Cumberst				City or Town, State, D 20776	Zip Code)
altimore,	Pages 1 and nent of He sent: If item ury or oth		20a. Method of Disposition 1 □ Burial 2 ▼Cremation 3 □ Remo 1 □ Donation 5 □ Other (Specify)	val from State	metery, cren	sition (Name of natory or other place)  Cremat		March 2006	3,	oc. Location - City or	
■ Balt	permit. Departr Importe eny inj		21. Signature of Funeral Service Licensee	Otto MO12	51 Be	everly L	. Heckr	rotte,	P.A.	e P.O. B Clarksvil	le. MD 21029
	Physician /Medical		23a. Part1. Enter the disease, or complication shock, or heart failure. List only one call immediate Cause (Final disease or condition resulting in death)	Lung Cein	cer	er the mode of dy	ng, such as ca	ardiac or re	spiratory arres	51,	Approximate Interval Between Onset and Death I mon #U
	Examiner	er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or a a conseque							
8760,	icate be executed physician and s the burial-transit	al Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conseque	ence of):						
9	entificate ding physse as the	/Medic	IF FEMALE:	vos cutomo of pro-							
P.O. Box	that the death certific ed by the attending p detached for use as t	Physician/Medical	in the past 12 months?	yes, outcome of pregnan  Live birth 2 Fetal of  Pregnant at time of dea  Unknown	death 3 🗆	Ectopic pregnand Other (specify)	У			23d. Date of de Month	Day Year
	The law requires that the death certific tie has been signed by the attending page 2 should be detached for use as	ρλ	Part II. Other significant conditions contribu	ting to death but not resul	ting in the ur	iderlying cause gi	ven in Part I.				o the cause of death?
Il Records,	: The law recate has be page 2 sho	Completed							24a. Was an autopsy perform	prior to ed? death?	utopsy findings available completion of cause of
Vita	sicien: The sicient of sicertificate lirector, pag	o Be	25. Was case referred to medical examiner?  1 Yes 2 XNo Hospi	al: 1 ☐ Inpatient 2 ☐ E	P/Outpation	t 3 DOA Ot			heck only one	) ice 6 □Other (Spe	orfice)
Division of Vital	To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate his completely filled in by the funeral director, page	atlon; To			28b. Time of Injury	28c. Inju	4 🗀 14015	28d.	-	v injury occurred	city)
Divis	itel or Atters after de el Directo	Certification;	3 Suicide 6 Could not be 4 Homicide determined 28	le. Place of Injury - At hom building, etc. (Specify)	10, farm, stre	eet, factory, office		28f.	Location (Stre City or Town,	eet and Number or R State)	ural Route Number,
	To the Hospitel or within 24 hours after To the Funerel Direction of the Funerel Direction of the Funerel Direction of the Funerel of the Fun	edical	(Check only 2 Medical Examiner: one)	ınd manner stated.	on and/or inv	estigation, in my	opinion, death	occurred a	t the time, dat	e and place, and due	to the cause(s)
	To the within 2 To the complet	M	29b. Signature and title of certifier	2		29c. Licen	se number		290	d. Date signed (Mont	h, Day, Year)
11	)		30. Name and address of person who comple	ted cause of death (Item :	23a) (Type. I	Print)	3856	3	- 1	rearch di	400 6
	60		Layre O. Bic	,690m NO	13	4 Men	sulla	RO	Wist	River	MO
	Sta Registr		31. Date filed (Month, Day, Year) #AR 0 3 2006	ted cause of death (Item:  O O O M  32. Rigistrar's Signatu	ti.	234					

			1 - For State Registrar		ryland / D	epartment of Certificate of	Health and	Mental Hygie	-	07941
	Physici /Medic Examir	cal	Decedent's Name (First, Middle, Las Reginald Bernard     Resility Name (If not institution, give 944 Beacon Way	Chambers,		An	or Location of Deal	th		Arundel
24 240	Funeral Director		5. Social Security Number 220–22–3388 St. Usual Residence of Decedent	X 7. Age	76 Y	day) If Under 1 Yea Months Day				hptace (State or Foreign aryland
	e Marylan 8a-f show	ctor	Maryland   10b. County   Anne Ar	rundel	10c. City, Town		polis			10d. Inside City Limits 1 ☐ Yes 2√2No
	ath with th	ral Dire	10e. Street and Number 944 Beacon Way			10f. Zip Code	21401	10g	U.S.A.	-
036	ours after degral, or Iteme	by Fune	11. Marital Status  1 ☐ Never Married 2 ◯ Married  3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent E Armed Forces? 1 ∑Yes 2 □ N If Yes, Give Year or Dates: 1	0	13. Was Decedent of If Yes, specify Cu 1 ☐ Yes 2 X No.		Specify Yes or No- to Rican, etc.)	14. Race - Ame Black, White Specify: W	
Maryland 21215-0036	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or Iteme 23s or 28s-f show ant, the Mudical Exatr fractritual te notified at	Completed by Funeral Director	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12) 12	ucation fe completed) College (1-4or 5-		Decedent's Usual Occi Give kind of work don life. DO NOT use retir Manage	e during most of wo ed)	orking 16	ib. Kind of Business/ Telephone	
/land	uld be filed Mental Hyg Irkad othe Itic event,	To Be C	17. Father's Name (First, Middle, Last) Reginald Bernard	Chambers,	Sr.			me (First, Middle, Ma Frank		
, Mary	and 2 sho balth and 1 n 27 is ma		19a. Informant's Name/Relationship (T) Nettie H. Chambe			Mailing Address (Stree 44 Beacon				Zip Code) 401
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Deparment of Health and Mental Hygiene.  Important: If itam 27 is marked other than "natural", or Iteme 23e or 28e-1 show any injury or other traumatic event, the Marical Examinating months any injury or other traumatic event, the Marical Examinating months and once.		20a. Method of Disposition  1 Burial 2 Toremation 3 4 Donation 5 Other (Specify,  21. Signature uneral service Licenses	1	cemetery,		atory 3/1 ess of Facility Jo	/2006 Br hn M. Tayl		Maryland
,092	Physician by Medical Examiner and street private in the private in	dical Examiner	23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if ally, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Preud Bue to (or as a Due to (or as a c.	consequence of	):	ing, such as cardia	c or respiratory arresi		Approximate Interval Between Onset and Death Weeks
P.O. Box 68	uires that the death certific signed by the attending p d be detached for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome o 1 □ Live birth 2 4 □ Pregnant at t 9 □ Unknown	Petal death	3 ☐ Ectopic pregnan 5 ☐ Other (specify)	су		23d. Date of deli Month	ivery Day Year
rds, P	w requires that been signed b should be deta	by	Part II. Other significant conditions co dehydration		•	he underlying cause g	iven in Part I.		cco use contribute to	V
al Reco	eician: The law requ certificate has been irector, page 2 shouli	Completed		ficiency				24a. Was an autopsy performe	24b. Were au prior to death?  (No 1   Yes	topsy findings available completion of cause of 2 No
Division of Vital Records,	tending Phy leath. tor: After this the funeral d	Certification: To Be	25. Was case referred to medicat examiner?  1  Yes	Hospital: 1 ☐ Inpatien  28a. Date of Injury (Month, Day	Year) 28b. Tin	ne of ury M 1 [	ther: 4 Nursing H ury at ork? Yes 2 No	ath (Check only one) Home 5 Residence 28d. Describe how	injury occurred	
DIV	To the Hospital or Atten within 24 hours after deat To the Funaral Director: completely filled in by the		4 Homicide determined  29a. Certifier 1 Certifying Phy	building, etc.	(Specify)	n, street, factory, office	ume, date and place	City or Town, S	se(s) and manner as	etated
)	To the Hospita within 24 hours To the Funaral completely filled	Medical	29b. Signature and address of person who a	and manner state	examination and/	29c. Licer	opinion, death occurse number 47311	urred at the time, date	and place, and due Date signed (Month	to the cause(s)
	Sta Registr		Dr. Cynthia Huffa 31. Date filed (Month, Day, Year)	ker 20	5 Ridge	ly Avenue	Annapoli	s, MD 2140	)1	

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician FEBRUARY** 1:15P 23 2006 SHERRI /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner 1204 ELSA AVENUE PRINCE GEORGE'S LANDOVER If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign
Country) 5. Social Security Number **Funeral** 1 □ M 2 🖾 F MARYLÁND 1969 217-06-2818 36 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County rthen "naturel", or iteme 23a or 28e-f ehow the Medical Examinar must be notified at 1 Yes 2 □ No Director LANDOVER MD PRINCE GEORFE'S 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20785 U.S.A. 1204 ELSA AVENUE Funerai 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 █ No 11. Marital Status hours after 1 Never Married 2 ☐ Married BLACK Maryland 21215-0036 1 ☐ Yes 25 No Specify: Specify: ģ 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 72 permit. Peges 1 and 2 should be filed within 72 Depertment of Health and Mental Hygiene. Important: If Item 27 ie marked other then "na eny injury or other treumatic event, tre Madic one. Elementary/Secondary (0-12) College (1-4or 5+) PRIVATE 12th ACCOUNTANT 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be AGNES FLETCHER OTHO C. CURRY 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1204 ELSA AVENUE LANDOVER, MARYLAND AGNES CURRY/MOTHER Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State RESURRECTION CEMETERY 3/4/2006 CLINTON, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME 21. Signature of Lineral Service Licensee 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** HYPOPHARYNX CARCINOMA /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): Box 68760, physicien the use as attending IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month Year ō in the past 12 months? 1 ☐ Yes 2 ☒ No 4☐Pregnant at time of death 5 Other (specify) signed by the a d be detached f o 9 Unknown ے 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ģ 2 X No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificete has briegetor, page 2 s autopsy performe 2∕□ No 1 Yes 2 No 1 Tes Hospital or Attending Physician: director. 25. Was case referred to medical 26. Place of Death | Check only one Be Hospital: 1 ☐ Inpatient Other: 4 ☐ Nursing Home 5X Residence 6 ☐ Other (Specify) 1 ☐ Yes 2QNo 2 ER/Outpatient 3 DOA Certification: To this funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After 5 Pending investigation 1 XNatural 1 ☐ Yes 2 ☐ No death. 2 Accident Director: / Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide hours efter Within 24 hours erre To the Funerel Dir Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifie Medical (Check only one and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and FEBRUARY 28, 2006 D29675 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6420 ROCKLEDGE DRIVE # 4100 BETHESDA, MARYLAND 20817 BOCCA M.D. RALPH 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

MAR 0 1 2006

			For State Registrar	State of	Marylar		artment rtificate			Mental I	lygieni Reg. No	006	07943
Pe	Physicia	n	Decedent's Name (First, Middle							2. Date of Month	Da	y Year	
	/Medica	al .		ERTRAM LOW		NNER	45 Ois 3		Lagation of Da		23 20	06 . County of Dea	15:20 "
	Examine	9_	4a. Facility Name (If not institution LAUREL REGIO)	NAL HOSPI	TAL		LA	UREI			P	RINCE	GEORGE'S
	Funeral Director		5. Social Security Number  577-62-3939  Usual Residence of Decedent	6.Sex IX□M 2□F	7, Age (In yrs.	58 Yrs.	Months	Days	If Under 24 Hi Hours Mi		Day, Year,		nthplace (State or Foreign ountry) BIRM., A
	Maryland	tor	10a. State 10b. County	GOMERY		ity, Town or Lo		NG					10d. Inside City Limits 1 X Yes 2 No
	h with the	al Direc	10e. Street and Number 3301 HAMPTO	N PL., #E	3		10f. Zip	Code 9 0 4				tizen of What C	•
36	72 hours after death with the Maryland natural, or iteme 23e or 28e-f ehow lical Exarch or must be redified at	by Funeral Director	11. Marital Status  1 ★ Never Married 2  Mar  3  Widowed 4  Divorced	12. Was Dece Armed For 1 X Yes If Yes Give	dent Ever in U ces? 2 [] No e			ent of His fy Cubar		Specify Yes or erto Rican, etc.		14. Race - Am Black, Wh	erican Indian, ite, etc.
Maryland 21215-0036	within ene. then "	Completed		nt's Education st grade completed)  College (1-	4or 5+) 'RS	(Give	DO NOT us	k done d	uring most of w	orking		(ind of Business	ŕ
yland 2	be fill d oth even	Be	17. Father's Name (First, Middle, ROBERT CONNE)	Last)		,	<u> </u>			ame (First, Mic E MCCU	dle, Maidei		321 2
, Man	s 1 and 2 should f Health and Mer tem 27 is marke other traumatic	- 1	19a. Informant's Name/Relations ROBERT F. COI			1	-					or Town, State, 1 LARG	
Baltimore,	9 ° = 5		20a. Method of Disposition 1 □ Burial 2 ☑ Cremation 4 □ Donation 5 □ Other (5	Specify)	State	Place of Dispo cemetery, cres IESAPE	matory or ot	her place	- 1	Date 27-06		ocation - City o	r Town, State
Balt	permit. Pag Department Important: eny injury o		21. Signatur of Funeral Service	thur.	Jale	ly 1		1ARY	LAND .	AVE.,	N.E.		RTUARY , D.C.200
	Physician /Medical		23a. Part 1. Enter the disea e lo sfock, or heart failure lis Immediate Cause (Final disease or condition resulting in death)	a	ich line.	/ RDIAL 1				ac or respirato	y arrest,		Approximate Interval Between Onset and Death
	Examiner	nlner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury	b. Due to (	or as a conse	STIVE In quence of): ARY ART					-		years
8760,	ate be execute hysicien and the burial-trans	dical Examin	that initiated events resulting in death) Last	d.	or as a conse								
O. Box 6	E S	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		nth 2 ☐ Fetant at time of	af death 3	⊒Ectopic pre □ Other (spe					23d. Date of de Month	elivery Day Year
rds, P	igne bed	۵	Part ff. Other significant conditi	ons contributing to de	ath but not re	sulting in the u	nderlying ca	tuse give	on in Part f.			-	to the cause of death?  Probably 4 □Unknown
Vital Records,	The ete ha	Completed		224-						24a. V	utopsy erformed?	prior to death?	autopsy findings available completion of cause of
Vita	cian	Be	25. Was case referred to medica examiner?	Hospital				01-	· ·	eath (Check or			
ō	ding Physi T. After this of funeral dire	on: To	1 X Yes 2 □ No  27. Manner of Death 1 X Natural 5 □ Pendi	28a. Date o		28b. Time o Injury	f 21	Bc. Injury Work	at			6 Other (Sp	ecify)
ivision	r Attending er death. rector: Afte by the fune	tification:		not be 28e. Place	of fnjury - At h	home, farm, st	m reet, factory		/es 2 □No		on (Street a Town, Stat		Rural Route Number,

To the Hospitel or within 24 hours after To the Funerel Director Completely filled in the completely filled in the completely filled in the complete of the co State

COREY CARTER 31. Date filed (Month, Day, Year) MAR 0 1 2006

29b. Signature and title of certifier



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

LT

DHMH 17 Rev 1/2001

Registrar

Medical Cer

29a. Certifier

1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

0101236858 (VA)

BETTESDA MD 20889-5600

29d. Date signed (Month, Day, Year)

NATIONAL NAVAL MEDICAL CENTER

			1 - For State Registrar	State of Ma	aryland / Depa	artment of F			giene Reg/No.006	07944
	Physici	ian	1. Decedent's Name (First, Middle, Last Elmer Gustav Cai					2. Date of De	ary 25, 200	3. Time of Death 9:40 p M
	/Medio Examir		4a. Facility Name (If not institution, give Lorien Nursing & F	street and number)		4b. City, Town, c			4c. County of Dea	uth
	Funeral Director		5. Social Security Number 150-30-8552  Usual Residence of Decedent	x 7. Ag	e (In yrs. last birthday) 85 Yrs.	If Under 1 Year Months Days	If Under 24 Hours	8. Date of Bir Min. Feb 3,		thplace (State or Foreign ountry) Jersey
	Maryland f show	tor	10a. State 10b. County  Maryland Carrol	1	10c. City, Town or Lo	cation	Westm	inster		10d. Inside City Limits 1 ☐ Yes 2 No
	h with the 3a or 28a	Funeral Director	10e. Street and Number 2617 Mayberry Roa	nd		10f. Zip Code	21	158	10g. Citizen of What C	•
9800	be filed within 72 hours after death with the Maryland tal Hygiene. Id other than "natural", or Itams 23a or 28a-f show event, Ire Madical Exeminant continued to reptified at	by	11. Marital Status  1   Never Married 2   Married 3   Widowed 4   Divorced	12. Was Decedent Armed Forces? 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates:	No	Was Decedent of F f Yes, specify Cub 1 ☐ Yes 2X No		n? (Specify Yes or No Puerto Rican, etc.)		
Maryland 21215-0036	filed within 72 h Hygiene. thar than "natu int, It e Medica	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	cation le completed) College (1-4or 5	(Give	dent's Usual Occup kind of work done DO NOT use retired Farmer	pation during most of d)	of working	16b. Kind of Business Agricul	
/land	should be filed nd Mental Hygid markad othar umatic evant, III	To Be C	17. Father's Name (First, Middle, Last) Joseph Cameron					s Name (First, Middle arl "Unkno		
	nd 2 sh alth and 27 is rr ir traum		19a. Informant's Name/Relationship (T) Frank Elgersma, o		2643	Robert A		Road, Wes	er, City or Town, State, tminster, M	D 21158
Baltimore,	permit. Pages 1 a Department of Hez Important: If itam any injury or otha		20a. Method of Disposition 1 元 Burial 2 □ Cremation 3 元 1 □ Donation 5 □ Other (Specify)			sition (Name of natory or other place)  Cemete		3/04/2006	20c. Location - City of Gettysbu	
Bal	permit Depart Impor any in		21. Signature of Funeral Service Licens	July	5		Stree	t, Westmir	rboraw Fundaster, MD 2	
	Priysician		23a. Pan 1. Enter the disease, or complete shock, or heart failure. List only of the same	ne cause on each lir	I the death. Do not ent ne. I-I AREAL	C100-100			rrest,	Approximate Interval Between Onset and Death
8760,	death certificate be executed  e attending physician and dor use as the burial-transit	ledical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, (Disease or injury	Due to (or as	a consequence of):  A NT a consequence of):	LYMP	HO M	A		
.O. Box 68	death certifi e attending p id for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	3c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal death 3	Ectopic pregnancy Other (specify)	4		23d. Date of de Month	livery Day Year
rds, P.	sign d be	by	Part II. Other significant conditions co	ntributing to death b	ut not resulting in the u	nderlying cause giv	en in Part I.		obacco use contribute t Yes 2□No 3□P	
Division of Vital Records,	The law ate has b page 2 sl	Completed						24a. Was autoj perfo	an 24b. Were a prior to death?	utopsy findings available completion of cause of
Vita	Physician: Th this certificate ral director, pag	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	lospital: 1 ☐ Inpatie	ent 2 ER/Outpatien	t 3 DOA Oth		f Death (Check only o		7,
ion of	ding After fune		27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injur (Month, Day	ry 28b. Time of	28c. Injur Wor		28d. Describe	dence 6 Other (Spe how injury occurred	city)
Divis	Dirte	Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Inju- building, etc	ury - At home, farm, str c. (Specify)	eet, factory, office		28f. Location ( City or To	Street and Number or R wn, State)	ural Route Number,
	To the Hospital within 24 hours a To the Funaral Completely filled	edical	one)	sician: To the best oner: On the basis of and manner sta	examination and/or inv	occurred at the tir restigation, in my o	me, date and p pinion, death	place, and due to the occurred at the time,	cause(s) and manner a date and place, and du	s stated. e to the cause(s)
)	To the comple	Σ	29b. Signature and title of certifler	hh		29c. Licens	o 54	580	29d. Date signed (Mon 2/27/	(h, Day, Year)
	* 3		30. Name and address of person who co	M.O. 4	17 E Bal	t S#	D	, Taney	tom, M.	D 21787
	Sta <sup>-</sup> Registr		FEB 2 8 2		ar's Signature	South				

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) Month Day February 25, **Physician** 2006 3:03 рМ Cannon Martin /Medical 4c County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 3604 May Street Montgomery Silver Spring If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral №** M 2□ F 579-40-8680 73 May 19, 1932 Washington, Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County rai', or itame 23a or 28a-f ehow Examiner must be notified at 1 ☐ Yes 2 No Maryland Montgomery Silver Spring Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number death with 3604 May Street 20906 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑Yes 2 ☐ No 11. Marital Status 1 and 2 should be filled within 72 hours after of Health and Mental Hygiene. am 27 is marked other than "natural", or itan 1 □ Never Married 2 □ Married Specify.White Baltimore, Maryland 21215-0036 1 Yes 2 XNo Specify: If Yes, Give Year or Dates: 1951-54 ğ 3 Widowed 4 Divorced I'm Medical E Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) D.C. Metropolitan Elementary/Secondary (0-12) College (1-4or 5+) Police Department 1 Police Officer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Martin H. Cannon Sara Geoghegan other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2:
Department of Health ar
Important: If Itam 27 is
any Injury or other trau Michelle Wertz/ Daughter 3839 Calmes Neck Lane, Boyce, Virginia 22620 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 28, Filver Spring, Maryland February Inlury 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Gate of Heaven Cemetery 2006 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Fapility. Francis J. Collins Funeral Home Inc 500 University Blvd, W, Silver Spring, MD 20901 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician Metastatic Melanoma 10 Months disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, I arry, loading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of) Examiner The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician Physiclan/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4 Pregnant at time of death 5 Other (specify) the a 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à should be 1 Yes 2 No 3 Probably 4 Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an certificate 1☐ Yes 2⊠ No To the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death Check only one Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To this 28a. Date of Injury (Month, Day Year) filled in by the funeral 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 27. Manner of Death 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide determined 4 Homicide within 24 hours a To the Funerel C t Centrying Physician: To the best of my knowledge death occurred at the time, date and place, and due to the causa(s) and mark of as stated 2 ■ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) DON: Confficient Medical and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signati D29675 February 27, 2006 15 1 ress of person who completed tuse of death (Item 23a) (Type, Print) Ralph Boccia, M.D 6420 Rockledge Drive, #4100, Bethesda, MD 20817 31. Date filed (Month, Day, Y 32. Redistrar's Signature State 0 2008 Registrar

			1- For Amend Item	State of Mar 26 per Dr.	ryland / Depa <b>G854,04/2</b>	artment of H 1/06dhb Tificate of L	lealth and Death	Mental Hygie	ene 6	07941
			Decedent's Name (First, Middle, La					2. Date of Death		3. Time of Death
	Physici /Medic		Irving Dav	is				February	28,2006	8:30a M
	Examin		4a. Facility Name (If not institution, given			4b. City, Town, or			4c. County of Death	
			32 Hubis Lane			Risina	Sun		Ceci1	
	Funeral		5. Social Security Number 6.3		(In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs Hours Min		(ear) 9. Birth	place (State or Foreign intry)
	Director		221-10-3021	₩ <sup>2□</sup> F 7	6 Yrs.	Bayo	110010	Septemb	er 14,19	29 DE
	and w		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or Lo	cation			7	10d. Inside City Limits
	danyl f sho	ō	MD Condit		Dieir	Cun				1 ☐ Yes 2 <b>]</b> No
	28a-	Director	MD Cecil  10e. Street and Number		KISII.	g Sun		100	. Citizen of What Cou	intry?
	3a or		32 Hubis Lan	Θ.		2191	1		U.S.A.	,
	ms 2	Funeral	11. Marital Status	12. Was Decedent Ev		Was Decedent of Hi	spanic Origin? (	Specify Yes or No-	14. Race - Amer	
36	be filed within 72 hours after death with the Maryland ital Hygiene. d other than "natural", or Items 23s or 28s-f show event, I're Modical Exacilier coast to coasting at		1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces?  1 ☐Yes 2 ☐ No If Yes, Give 1 Year or Dates:		f Yes, specify Cuba 1 □ Yes 2🎞 No	n, Mexican, Pue Specify:	rto Rican, etc.)	Black, White	, etc. hite
5-003	tural stural	Completed by	15. Decedent's E	Tour or Batos.		dent's Usual Occupa	ation	16	6b. Kind of Business/l	ndustry
	n "ne	plet	(Specify only highest gr		life I	dent's Usual Occupa kind of work done o DO NOT use retired	during most of wo	orking	o. Italia of Dadillogari	idustry
2121	d with giene or tha	E	Elementary/Secondary (0-12)	2		rpenter			Constru	ction
	m - 0 %	Be C	17. Father's Name (First, Middle, Last	")			18. Mother's Na	ime (First, Middle, Ma	uiden Sumame)	
<u>a</u>	should be and Mental   s marked o umatic eve	To	Leonard Davis				Lilli	e Reed		
Maryland	2 sho and l		19a. Informant's Name/Relationship		19b. Mailir	ig Address (Street a	and Number or F	Rural Route Number, C		
	and 2 ealth m 27 I		Irving R. Davi	s/Son		044	n Rd.,	Kirkwoo		7536
altimore,	Pages 1 nent of H int: If ite		20a. Method of Disposition  1   Burial 2   Cremation 3   [	Removal from State	20b. Place of Dispo cemetery, cren	sition (Name of natory or other plac	θ)		c. Location - City or T	own, State
Ē	Pag tment tant: jury o		`4 ☐ Donation 5 ☐ Other (Speci	fy)	R.A.Ferr	is Inc.		ch 3, W	est Ches	ter, PA
Bai	permit. Pages 1 and 2 should by Department of Health and Menia Important: If item 27 is marked any injury or other traumatic a QDCe.		21. Sonature of Fuge (4.8) rvice Lice	nsee		Name and Addres		Funeral	Home	
	40 5 8 Q	The f				25.9 E. M	ain St	., Elkto	n, MD 2	1 0 2 1 proximate
			23a. Part1. Enter the disease, or conshock, or heart failure. List only	one cause on each line	ne death. Do not ent	er the mode of dying	g, such as cardia	ic of respiratory arrest	t,	Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	a netaal	auc 131	aplder	Coen	cer		unk
	/Medical Examiner		rosuming in docum	Due to (or as a	consequence of):					
		e	Sequentially list conditions, if any, leading to immediate	b. Que to for as a	consequence of):					
	rted nsit	nin	Cause (Disease or injury							
,	execu n and ial-tra	Examin	that initiated events resulting in death) Last	c. Due to (or as a	consequence of):					
68760	ficate be executed physician and the burial-transit	edicail		d						
_										
X R O	leath certific attending p	ian/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of 1 ☐ Live birth 2		Ectopic pregnancy			23d. Date of deliv	rery
9	deat	sicia	in the past 12 months? 1 \( \subseteq \text{Yes}  2 \subseteq \text{No} \)	4□Pregnant at tii		Other (specify)			Month	Day Year
J.	at the de by the a stached	Physicia	9 🗆 Unknown							
Vital Records, I	law requires that the death certi as been signed by the attending 2 should be detached for use a	by	Part II. Other significant conditions	contributing to death but	not resulting in the ur	nderlying cause give	en in Part I.	·	cco use contribute to 2 ☑ No 3 ☐ Pro	the cause of death?  bably 4 □Unknown
ö	w require been si should b	ete					-	24a, Was an		
ĕ	sician: The law certificate has b irector, page 2 s	Completed					· · · · · · · · · · · · · · · · · · ·	autopsy performe	prior to co	opsy findings available ompletion of cause of
co.	n: The	e Co	25. Was case referred to medical	<del></del>				1□ Yes 2 🖢		2 No
	Physician: r this certific ral director,	o Be	examiner?	Hospital: 1 ☐ Inpatient	2 ER/Outpatien	t 3 DOA Othe		ath <i>(Check only one)</i> Home 5 <b>∑</b> Residence	o 6 Dothar (Same	(5.1)
o	g Phys	H	27. Manner of Death	28a. Date of Injury	28b. Time of	the second second		28d. Describe how		ly)
0	Attending ir death. ector: After by the funer	ation	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day )	Yea <i>r)</i> Injury		(? /es 2 □ No			
Division	r Attendi er death. rector: A by the fu	Hice	3 Suicide 6 Could not be determined	28e. Place of injury	y - At home, farm, stre	eet, factory, office			et and Number or Rui	al Route Number,
ב	tal or	Certification:	4 - Hornida	building, etc.	(эрвспу)			City or Town, S	Siale)	
	To the Hospital or Atten within 24 hours after deat To the Funeral Director: completely filled in by the	edical	29a. Certifier 1 Certifying Pl	nysician: To the best of miner: On the basis of e and manner state	xamination and/or inv	occurred at the time restigation, in my op	e, date and plac pinion, death occ	e, and due to the caus urred at the time, date	se(s) and manner as	stated. to the cause(s)
	To the vithin To the	Me	29b. Signature and title of certifier	h	. \	29c. License	number	29d	. Date signed (Month)	Day, Year)
	->-0		> V. \( \)	n day	2 MI	) DZ	3099		2/28/06	
			30. Name and ddress of person who	completed cause of dea	th (Item 23a) (Type.	Print)	( )		-1-0100	
5-	FIVA		Dr. Promila S.		W. High		Kton. 1	no 2192	1	
	Sta	te	31. Date filed (Month Pay, Year)		s Signatur					
	<u> </u>		INTERNATION OF THE CO.	/ IIIII / Water and	01 15 150	0720				

		•	_ POI	eartment of Health and Me ertificate of Death	ntal Hygier	(UUD 11/340
			Decedent's Name (First, Middle, Last)	2	Date of Death	3. Time of Death
	Physicia /Medic		JAMES R. DUI,N		MARCH	1 2006 1120A M
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4	Ic. County of Death
			5. Social Security Number 6. Sex 7. Age (In yrs. last birthda)	ELKTUN  If Under 1 Year   If Under 24 Hrs.   8	. Date of Birth	9. Birthplace (State or Foreign
	Funeral Director		213-36-9076 1 1 2 F 68 Yrs.	Months Days Hours Min.	(Month, Day, Yea	ar) Country)
	D		Usual Residence of Decedent			
	show	-	10a. State 10b. County 10c. City, Town or			10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	the M	Director	MD Cecil F1kto	On 10f. Zip Code	100.0	Citizen of What Country?
	3a or		129 Cherry Tree Drive	21921		J.S.A.
	death ms 2:	Funeral		. Was Decedent of Hispanic Origin? (Specifi If Yes, specify Cuban, Mexican, Puerto Ric		14. Race - American Indian, Black, White, etc.
9	or Ite	Fu	1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☑ No	1 ☐ Yes 2 ☐kNo Specify:	san, etc.)	Specify: White
21215-0036	72 hours after death with the Maryland "natural", or Items 23a or 28a-1 show offical Examinations to collified at	d by	3 U Widowed 4 Divorced Year or Dates:	edent's Usual Occupation	165	Kind of Business/Industry
5	- 40	Completed	(Specify only highest grade completed) (Giv	e kind of work done during most of working DO NOT use retired)	100.	Kind of business industry
212	filed within Hygiene. other than "I	mo	Elementary/Secondary (0-12) College (1-4or 5+)	pair Tech	Cl	rysler Corp.
멀	be filed ital Hygi d other avant.	BeC	17. Father's Name (First, Middle, Last)	18. Mother's Name (i	First, Middle, Maid	en Surname)
Maryland		2	James Graham Dulin	Nellie F		
Mar	d 2 s th ar 7 is trau			ling Address (Street and Number or Rural F		
	s 1 and 2 f Health Itam 27 I		20a Method of Disposition 20b. Place of Dis		e 20c.	ton, MD 21921  Location - City or Town, State
E	Pages nent of I int: If its iry or o	13	1 XBurial 2 □ Cremation 3 □ Removal from State  '4 □ Donation 5 □ Other (Specify)  Cherry	Hill March	~ \chi	erry Hill, MD
Baltimore,	permit. Pages Deportment of Important: If i any injury or ance.			Name and Address of Facility		
<u> </u>	9 Q E 2 9	1	THE STATE OF THE S	Andrew G. Gee	runera:	. ноте on, MD 21921 <sub>e</sub>
			23a. Part1. Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line.	nter the mode of dying, such as cardiac or r	espiratory arrest.	Interval Between Onset and Death
	Prysician	1	Immediate Cause (Final disease or condition resulting in death)	PNEUMONIT		2 weeky
	/Medical Examiner		Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate  Due to (or as a consequence of):  b. Acute Ness in the condition of	chia Galue		2 day
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury)	4100 1100		30095
VI.	cuted hd ransit	Examiner	Cause (Disease or injury that initiated events	FAJUM		3 dsys
00	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burfal-transit		resulting in death) Last Due to (or as a consequence of):			
8760	icate b physic the b	dical	d			
9 xo	eath certific attending p I for use as	Physician/Me	IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of delivery
B	death a atter d for u	lciar	in the past 12 months?  4 Pregnant at time of death 5	☐ Ectopic pregnancy ☐ Other (specify)		Month Day Year
P.0	t the by the tache	hys	9 □ Unknown			
	res that the de signed by the a be detached i	by	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacc	o use contribute to the cause of death?
ecords,	w require been sign	Completed				, _
Rec	has t	mpl			24a. Was an autopsy performed	24b. Were autopsy findings available prior to completion of cause of death?
2		e Co	25. Was case referred to medical	26. Place of Death (	1 Yes 2 1	No 1 Yes 2 No
Vital	Physician: The this certificate har director, page	O B	examiner? 1 ☐ Yes 2 ☑ No Hospital: 1 _ npatient 2 ☐ ER/Outpati	Other		6 ☐Other (Specify)
n of	를 를 풀	n: T	27. Manner of Death 1 ☑ Natural 5 ☑ Pending (Month, Day Year) 28b. Time (Month, Day Year)		d. Describe how in	jury occurred
Siol	r Attending er death. rector: After by the fune	catle	2 Accident investigation	M 1 ☐ Yes 2 ☐ No		
Division	or At after d Direct in by	Certification:	3 ☐ Suicide 6 ☐ Could flot be determined 4 ☐ Homicide determined 28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office 28	f. Location (Street City or Town, St.	and Number or Rural Route Number, ate)
_	To the Hospital or Attent within 24 hours after deatl To the Funeral Director: completely filled in by the		29a. Certifier 1 Certifying Physician: To the best of my knowledge, de	ath occurred at the time, date and place, an	d due to the cause	(s) and manner as stated.
	ne Hora	Medical	(Check only 2 Medical Examiner: On the basis of examination and/or	investigation, in my opinion, death occurred	at the time, date a	
	To the To the Comp	ž	29b. Signature and title of certifier	29c. License number	29d. [	Date signed (Month, Day, Year)
•			Will Spen X m	D0062759	M,	Arch 1 2006
	jD		30. Name and address of person who completed cause of death (Item 23a) (Typ	e, Print)	1401/11	
	Sta		31. Date filed (Moath, Day, Year) 32. Jegistrar's Signature	29c. License number  D0062759  e, Print)  ST EUCT- M	· ney con	
	Regist	rar	min on Love parties to			

1-	For State Registra
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State of Maryland / Department of Health and Mental Hygiene

			1 - State Registrar			Certi	ificate of i	Death		Re	g. No.			
			1. Decedent's Name (First, Middle, La	ist)					2	2. Date of Death		Vana	3. Time of	Death
	Physici /Medi		Lorraine Phipps I	Diamond					1	Month Februar	y 24,	2006	11:43	РМ
ŀ	Examir		4a. Facility Name (If not institution, give		r)		4b. City, Town, or	r Location o			4	unty of Death		
1			Fairfield Nursing	& Rehabi	litation		Crowns	sville	€		Ann	ne Arun	del	
	Funeral		Social Security Number 6.5	Sex 7. A	ge (In yrs. last birth		If Under 1 Year Months Days	If Under 2	24 Hrs. 8 Min.	Date of Birth (Month, Day,	Year)	9. Birth	place (State or	r Foreign
	Director		216-28-0401	1□M 2XF 7	′1 Y	rs.	Wioritis Days	Hours	WIII.	7-21-1	934		land	
	P .		Usual Residence of Decedent		140 00 7									
	ahow	_	10a. State 10b. County		10c. City, Town							]	10d. Inside Cit 1 X Yes	•
	Ba-f	cto	Maryland Anne Ai	Tunaeı	Annap	OTT	.S						1 101 162	2 140
	if	Director	10e. Street and Number				10f. Zip Code			10	0g. Citizen	of What Coul	ntry?	
	ath w	a	930 Bay Forest Ct				21403					USA		
	eb re	Funeral	11. Marital Status	12. Was Deceder Armed Forces	:?	13. Wa	as Decedent of H (es, specify Cuba	lispanic Orig an, Mexican	gin? (Speci I, Puerto Ri	fy Yes or No- can, etc.)		Race - Americ Black, White,		
36	or i	by Fi	1 Never Married 2 Married	1 ☐ Yes 2 X		1 (	Yes 2X No	Specify:			Sp	ecity: Whi	te	
21215-0036	within 72 hours after death with the Maryland gne. than "natural", or items 23s or 28s-f show to Medical Examiner must be rectified at	d b	3 ☐ Widowed 4 ☑ Divorced	Year or Dates		\	-11-11-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1				ICh Kind	-4 D	-turntan	
5	n 72	Completed	15. Decedent's E (Specify only highest gr			Give kil	nt's Usual Occup nd of work done of NOT use retired	durina most	t of working	,	lob. Kind (	of Business/In	dustry	
12	withi ene. than	E	Elementary/Secondary (0-12)	College (1-4o	r 5+)		keeper	-7			ъ	Restaur	ant	
9	filled Hygi ther		17. Father's Name (First, Middle, Last	)		CON	veeber	18. Mothe	r's Name (	First, Middle, N			anc	
Maryland	12 should be filed within h and Mental Hygiene. 7 is marked other than " fraumatic avant, the Mex	o Be	Richard L.	Phipps					Marc	garet E	sabel	Bryan	1	
<u></u>	thoul mark mati	2	19a. Informant's Name/Relationship		19b.	Mailing	Address (Street	and Numbe		<b>-</b>				
Ma	permit. Pages 1 and 2 should be tiled within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23s or 28s -f show any injury or other traumatic avant, the Medical Experiment must be rectified at 2006.		Terry D. Ramsay/			_	aylor Av						•	
வ	Hea Hea tem		20a. Method of Disposition		20b. Place of I	Disposit	ion (Name of	<u>. T</u>	Da	te 2	20c. Locati	ion - City or To	own, State	
Baltimore,	ages ant of tr: if i		1 ☐ Burial 2 ☑ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci		8		ntory`or other place ematory		2-27-0	16	Edge	water,	MD	
Ħ	aritme ortan Injur		21. Signature of Funeral Service Lice		Natas		Name and Addres							<u> </u>
Ba	Deparing Department of the popular in popula		Ilahert Pela	1_		1	73 Solor			_				
			23a. Part1. Enter the disease, or com	plications that caus	ed the death. Do no	-	-					icci, i.	Approximate	е
			shock, or heart failure. List only Immediate Cause (Final	one cause on each	line.		,						Interval Bety Onset and D	
	Physician /Medical		disease or condition resulting in death)	a. Xung	Carcinar	MAL								
	Examiner		1	Due to (or a	s a consequence of	):								
		ē	Sequentially list conditions, if any, leading to immediate	b. Due to (or a	s a consequence of	):								
	petr	Examin	cause. Enter Underlying Cause (Disease or injury											
	execu al-tra	xai	that initiated events resulting in death) Last	c. Due to (or a	s a consequence of	):								
92	sicie		· ·	o d										
68760,	law requires thet the death certificate be executed as been signed by the attending physicien and 2 should be detached for use as the burial-transit	Medical												
×	nding use		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom	e of pregnancy						23d.	. Date of delive	ery	
Bo	death a atte	cla	in the past 12 months? 1 ☐ Yes 2 1 No 9 ☐ Unknown	4☐Pregnant	2 Fetal death at time of death		ctopic pregnancy Other (specify)	<u> </u>				Month	Day Y	/ear
P.O.	thet the death cer ed by the attendir detached for use	Physician	9 Unknown	9□ Unknown						· · · · · · · · · · · · · · · · · · ·				
	res thei signed b	by P	Part II. Other significant conditions	contributing to death	but not resulting in	the und	erlying cause give	en in Part I.		23e. Did tob	acco use	contribute to t	he cause of d	eath?
of Vital Records,	auire n sig	D D								1 ☐ Ye	s 2 🗆 N	lo 3 🗆 Prot	oably 4 💢	Jnknown
8	w requir s been si should	Completed								24a. Was ar	1 2	4b. Were auto	psy findings a	available
Re	The lav ete has page 2 :	E								autopsy	ned?	prior to co death?	mpletion of ca	ause of
tal	iiclan: Th certificete rector, pag		25. Was case referred to medical	1				26 Place	of Death /	1 ☐ Yes 2 Check only one	No	1 🗆 Yes	2100No	
5	Physician: this certifice ral director, p	To Be	examiner? 1 ☐ Yes 2 No	Hospital: 1 🗆 Inpa	tient 2 ER/Outp	atient	3□ DOA Oth			e 5 ☐ Reside		Other (Snecii	6c)	
	Phy er this eral o		27. Manner of Death	28a. Date of In (Month, C		ne of	28c. Injury		<del></del>	d. Describe ho			97	
Division	Attending I ir death. ector: After by the funer	atio	1 Natural 5 Pending 2 Accident investigation		nay rear) in	ury		k? Yes 2.⊟!	No					
N S	Attendii r death. actor: A by the fu	fice	3 ☐ Suicide 6 ☐ Could not b	28e. Place of I	njury - At home, farr	n, stree	et, factory, office		28	f. Location (Str		umber or Rura	al Route Num	ber,
á	all or s afte i Dire	Certification:	4  Homicide	building,	etc. (Specify)					City or Town	, State)			
	ospita hours iners y fille		29a. Certifier 1 Certifying P	nysician: To the bes	t of my knowledge,	death o	occurred at the tin	ne, date an	d place, an	d due to the ca	iuse(s) and	d manner as s	tated.	
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funersi Director: After this certificete his completely filled in by the funeral director, page	Medical	(Check only 2 Medical Exa	miner: On the basis and manner:	of examination and stated.	or inve	stigation, in my o	pinion, deat	th occurred	at the time, da	ate and pla	ice, and due to	o the cause(s	)
	To t To t	Σ	29b. Signature and title of certifer				29c. Licens	e number		29	d. Date si	igned (Month,	Day, Year)	
			FIL	MA			038	958	2	0	1/25	106		
			30 Name and address of person who	completed cause of	death (Item 23a) (T	ype, Pr				00	^			
_			Datient Sum	h double	208 C	OLIN	Huston	Day .	CW	Olin	Bul	nie 1	MOHO	261
		ate	31. Date filed (Month, Day, Year)	A CONTRACTOR OF THE CONTRACTOR	trar's Signature			/						4
	∡ Regist	rar	FEB 2 8	2006	me to	19	1046	/						
DI		1001		,		-								

DHMH 17 Rev 1/2001

LOUIS R. DAVIS 06-01613 RKD

1302

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			Amend  For State Registrer	Unpend ite	State of W	laryland		355,5/5/06 artment of h rtificate of		nd Mental Hy	gieņe Reg. No		0795	0
	Physic /Medi		1. Decedent's Name Louis	(First, Middle, Las R •	st)		Davi	s. <del>Jr.</del>		2. Date of D Month MARCH	Day		3. Time of De. 11:10A.	ath M
	Examir Funeral		4a. Facility Name (If 447 BOOTH 5. Social Security Nu	STREET 6.S	ex 7.A	ge (In yrs. la	st birthday)	4b. City, Town, of ELKTON If Under 1 Year	If Under 2	4 Hrs. 8 Date of Bi	CI CI	County of Deat ECIL 9. Birth	h hplace (State or Fo	nreion
	Director		222-54-5 Usual Residence of	Decedent	M 2 F	40	Yrs.	Months Days	Hours	Sept. Month 18	ay, Year)	965 WY	Tmingto	n,I
	the Maryla 28a-fahov colliled al	Director	MD  10a. State  MD  10e. Street and Num	Cecil			ton ton			1	40 00		10d. Inside City L 1 XYes 2[	
	ns 23e or	Funeral Dir		ooth St	reet	Ever in U.S	. 13.1	10f. Zip Code 2192		in? (Specify Yes or N	U	S.A.		
3036	72 hours after death with the Maryland Insturel', or Items 23s or 28s-1 show dical Examiring must be notified at	þ	1 Never Marrie		Armed Forces  1 Yes 2 N  If Yes, Give Year or Dates:	?		fYes, specify Cub 1 □ Yes 27 No		in? (Specify Yes or N Puerto Rican, etc.)		Black, White		
9500-9121	Mithin ne.	Completed		15. Decedent's Ed fy only highest gra ndary (0-12)		5+)	(Give life.	dent's Usual Occup kind of work done DO NOT use retired	pation during most d)	of working		ind of Business/I	•	
Maryland 21	be file ntal Hyg ad othe avant,	To Be Co	17. Father's Name (#	First, Middle, Last)						s Name (First, Middle ta Shaff	, Maiden		9	
	s 1 and 2 should ( Health and Men item 27 is marka other traumatic		19a. Informant's Nar Tina I 20a. Method of Dispo	David -		20h Pla	447			or Rural Route Numb Elkton, M Date	ID 2:	1921		
saitimore,	permit. Pages Depertment of the important: If ite any injury or of	0.000	1 ☐ Burial 2 🔀	☐Cremation 3 ☐ 5 ☐ Other (Specify		cen	netery, crer nily	natory or other plac Cremati	on 3/	9/2006	Wiln	-		
מׄ	Per imp		23a. Part1. Enter the shock, or heart	e disease, or comp	plications that cause	d the death.		TA PHIT	aderk	rvice of hia Pike ardiac or respiratory a	, W.	aware ilm., I	DE 1980 Approximate Interval Between	n
3/00,	Physician //Medical physician and physician and physician and physician its physician it was a secure of the physician in the	dical Examiner	Immediate Cause (F disease or condition resulting in death)  Sequentially list con if any, leading to immediate. Enter 'Inder Cause (Disease or in that initiated events resulting in death) La	ditions, mediate tying njury	Due to (or as	a conseque	once of): ophy ar once of).	nd dilatati	.on				Onset and Deat	h
O. Box 68	law requires that the death certifica as been signed by the ettending ph. . 2 should be deteched for use as th	Physician/Medi	IF FEMALE: 23b. Was decedent in the past 12 n 1  Yes 2  9 Unknown	nonths?	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal d	leath 3	Ectopic pregnancy Other (specify)	′		2	23d. Date of deli	very Day Year	
ecords, P	quires that en signed b	þ	Part II. Other signific Seizure di		ontributing to death t	out not result	ing in the ur	nderlying cause giv	en in Part I.				the cause of death	
итан жесо	60 60 60	Completed								1 Yes	psy ormed? 2 \Begin{array}{c} No	d ath	topsy findings avai ompletion of cause 2 \( \text{No} \)	able of
<u> </u>	ysicia is certi directo	To Be	25. Was case referre examiner?  Yes 2 N	1	Hospital:	ent 2 Ei	R/Outpatien	t 3 DOA Oth		of Death <i>(O e on i</i> sing Home 5 ☐ Resi	-	6 <b>V</b> ∏Other (Spec	(fv) SCENE	
DIVISION O	To the Hospital or Attanding Physician: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the tuneral director, page	Certification;	27. Manner of Death 1 Matural 2 ☐ Accident 3 ☐ Suicide	5 Pending investigation			8b. Time of Intury	M 1		28d. Describe			W DOMAE	
2	pital or At ours after of eral Direct filled in by		4 Homicide	determined	building, e	tc. (Specity)		eet, factory, office		City or To	wn, State,	)	ral Route Number,	
	To the Hos vithin 24 ho o the Fun completely	Medical	29b. Signature and ti	X Medical Exem	niner: On the basis of and manner st	of examinatio	edge, death n and/or inv	r occurred at the tir restigation, in my o	pinion, death	place, and due to the occurred at the time,	date and	and manner as diplace, and due to signed (Month	to the cause(s)	
)			30 Name and address	So of person who	completed gayse of	death (Item 2	3a) (Type,		.M.E.	1	MARCH	16, 200	6	
<b>P</b>	Sta	ate	31. Date filed (Month	0.00.00	32. Regist	rar's Signatu			STREE	ET BALTIMOI	RE, M	1ARYLAND	21201	-
DH	Registr MH 17 Rev 1/20			MAR 1 5 2	2006	m d		restlet						
							ORIGI	NAL.						

		1 - For State Registrar	State of Maryland	d / Depa	artme		aith and M	Mental Hygi	ene g. No. 0 0 6	07951
Physicia /Medic Examin	al	Decedent's Name (First, Middle, Last     HELEN  4a. Facility Name (If not institution, give     DOCTOR S HOSPI	L. D	AVIS	-	y, Town, or Lo	cation of Death	2. Date of Death Fellmuary	4c. County of De PRINCE G	ath
Funeral Director		5. Social Security Number 578-38-7430  Usual Residence of Decedent	x 7. Age (In yrs. It	ast birthday) Yrs.	If Und Month		Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, APRIL 6	9. B 1930 MA	irthplace (State or Foreign Country) ARYLAND
S sile	eted by Funeral Director	10a. State 10b. County  MD PRINCE G  10e. Street and Number  7414 BELLEHAVEN C  11. Marital Status  1 Never Married 2 Marned 3 XWidowed 4 Divorced.  15. Decedent's Edi (Specify only highest grad	EORGE S  OURT  12. Was Decedent Ever in U.: Armed Forces? 1  Yes, Give Year or Dates:	S. 13.	TTSV.  10f. 2  Was Decilit Yes, sp  1 Yes  dent's Us	20785 edent of Hisp pecify Cuban, 25 No	Specify:	pecify Yes or No- p Rican, etc.)	U.S.A.  14. Race - An Black, Wh Specify:  6b. Kind of Busines	nerican Indian, lite, etc. BLACK
d be filed within and Hygiene.	To Be Completed	Elementary/Secondary (0-12) 7th 17. Father's Name (First, Middle, Last) JAMES ENNIS	College (1-4or 5+)		IET I		3. Mother's Nam	ne (First, Middle, M BUTLER	GOVERN (aiden Sumame)	MENT
permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If them 27 is marked oth any injury or other traumatic event once.		19a. Informant's Name/Relationship (T) LEROY M. DAVIS J  20a. Method of Disposition 1 \( \mathbb{X}\) Burial 2 \( \mathbb{C}\) Cremation 3 \( \mathbb{I}\) 4 \( \mathbb{D}\) Donation 5 \( \mathbb{O}\) Other (Specify, 21. Signature of Funeral Service Licens	YATTSVILI Date 2 2006 6 B. JENK	City or Town, State  E, MARYLAN  Co. Location - City of  CHELTENHA  INS FUNER  R, MARYLAN	D 20785 or Town, State M, MARYLAND AL HOME					
Physician /Medical Examiner  per partial-transit	icai Examiner	23a. Part1. Enter the disgase, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. SEPTIC  Due to (or as a consequence of the total for a consequence of the total for a consequence of the consequence of the consequence of the consequence of the	SHOCK uence of):						Initerval Between Onset and Death
The law requires that the death certificate be executed ate has been signed by the attending physicien and page 2 should be detached for use as the burial-transit	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnal 1□Live birth 2□Fetal 4□Pregnant at time of de 9□Unknown	death 3[	]Ectopic ] Other (	pregnancy (specify)			23d. Date of o	lelivery Day Year
se un eq	þ	Part II. Other significant conditions co	ntributing to death but not resu	alting in the u	nderlying	cause given	in Part I.			to the cause of death?  Probably 4 XUnknown
Physicien: The law re this certificate has be al director, page 2 sho	e Completed	25. Was case referred to medical						24a. Was ar autopsy perform 1 \( \text{Yes} \) 2	prior t death No 1 Y	autopsy findings available o completion of cause of ? es 2Å No
Physicien: r this certifici	0	examiner?	Hospital: 1 🔀 Inpatient 2 🗆	ER/Outpatier	nt 3 🗆 [	Other		ith <i>(Check only</i> one ome 5 □ Reside	nce 6 ⊡Other (S)	pecify)
Jing After fune	Certification: T	27. Manner of Death  1	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	f M	28c. Injury a Work? 1 ☐ Ye		28d. Describe ho	w injury occurred	
To the Hospital or Attending in within 24 hours after death or to the Funerel Director: After completely filled in by the funer		4 Homicide determined  29a. Certifier 1 Certifying Phy	28e. Place of Injury - At ho building, etc. (Specify sician: To the best of my known	v) wledge, deat	h occurre	ed at the time.	date and place	City or Town	, State)	Rural Route Number, as stated.
he Ho in 24 he Fu pletel	Medical	one)	iner: On the basis of examinat and manner stated.	tion and/or in	vestigation	on, in my opin	ion, death occu			
To the vithin 2 To the complet	W	29b. Signature and title of certifier	M.O.			9c. License n		29	2 - 26	
26	to	30. Name and address of person who called the filed (Month, Day, Year)	ompleted cause of death (Item or M.D. 980 32. Registrar's Signal	1 Geo	Print)	Ave :	Suite 3	-41, 5,1vc	r Spring,	MO 20902
Sta Registr		MAR 0 1 2006	Blow &	Good	( )					

			For State							and M	ental Hy	giene	006	079	52
	A	9	1. Decedent's Name (First, Middle	Per Phys. R	9CH 3/3/(	ж егМ <sup>е</sup>	rtificat	e of E	Death	-		Reg. No.			40 1
. *	Physici			Ronald	d Eugene	Driver					2. Date of Dea	Day	2006	3. Time o	
	/Medic Examin		4a. Facility Name (If not institution,	Driver give street and num	nber)		4b. City,	Town, or	Location o	f Death			County of Dea		) Ari
124° 251° 1	LAUTIN	(C)	Southern Mary	land Hosp	ital		C1	into	n			P.	G.		
	Funeral	- 12		6. Sex 1X M 2 ☐ F	7. Age (In yrs.		If Under Months	1 Year Days	If Under 2	24 Hrs. Min.	8. Date of Birt (Month, Da	h v. Year)	9. Bin	thplace (State	or Foreign
-	Director		577-56-8266 Usual Residence of Decedent	MUM ZUF	6	2 Yrs.		,			2 1.	5 44	Was	h., DC	
	/land		10a. State 10b. County		10c. Cit	y, Town or Lo	cation							10d. Inside C	City Limits
	Man B-1 eh	tor	MD P.	G.	C	linton								₽ Yes	2 🗆 No
	or 28	Director	10e. Street and Number				10f. Zip	Code				10g. Citiz	en of What Co	ountry?	
	ath w	rail	8008 Max Fiel					20735			100	USA			
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Itam 27 is marked other then "naturel", or Itema 23a or 28a-f ehow any injury or othar traumatic event. The Medical Examiner must be notified at once.	by Funerai	11. Marital Status  1 □ Never Married 2 □ Marrie  3 □ Widowed 4 □ Divorced	12. Was Dece Armed For 1X Yes If Yes, Give Year or Da	ces? 2 [] No e		Was Deced f Yes, sped 1 □ Yes	cify Cubar	spanic Orig n, Mexican Specify:	gin? (Spe , Puerto I	cify Yes or No Rican, etc.)		4. Race - Ame Black, Whit Specify:		
2-0	72 ho	Completed	15. Decedent' (Specify only highest	s Education		16a. Deced	dent's Usua	al Occupa	tion	of workir	na	16b. Kin	d of Business	/Industry	
2	Men.	mpie	Elementary/Secondary (0-12)	College (1-	4or 5+)	1			uring most	OI WOTAII	,9	D		т 1 .	
7	Hygie Hygie ther ti		17. Father's Name (First, Middle, L	3+		Tech	nicia		18 Mothe	r'e Name	(First, Middle,			Indust	ry
Maryland	d be l	o Be	Melvin Driver								nderso		oumamej		
37	shoul nd Me marl	To	19a. Informant's Name/Relationsh	ip (Type, Print)		19b. Mailir	g Address	(Street a	nd Numbe	r or Rura	l Route Numbe	er, City or	Town, State, 2	Zip Code)	
	and 2 alth a 27 is		Corlette Driv	er <i>M</i> ife		8008	Maxfi	le1d	Drive	. C1	inton,	MD	20735		
Baltimore,	of He		20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, crematory or other place)  2724/06									20c. Loc	ation - City or	Town, State	
Ĕ	Pages tment of tant: if its jury or o		4 ☐ Donation 5 ☐ Other (Sp	ecify)	nato .	Harmon			1	'k'	, 00	Lan	dover,	MD	
Ba	Departiment Departiment Departiment Departiment Departiment Department Depart		21. Signature of Funeral Tervice L	in Wa	tto	Fr	azier	's F		1 Ho	ome, Ind	wa	9 Rhod	6. Isla	od 1 <sup>Ave</sup>
	Physician /Medical		23a. Part1. Enter the disease, or o shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)	- A Cui	te R	i gli	E H	em	is po	he	rection	Ce Ce	rebro	Approxima Interval Be Onset and	tween
8760,	cate be executed by sician and ithe burial-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	с	or as a consequence or as a consequence		ing		H e	91	+	f	culu	~ 4	dong
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	ysician: iis certific director,	To Be	examiner? 1 ☐ Yes 2X No	Hospital:	patient 2	ER/Outpatien	t 3 DO	Othor	~	-	(Check only on ne 5 ☐ Resid		□Other (Spe	cify)	
0 00	ding Phy h. After thi funeral c		27. Manner of Death 1 X Natural 5 ☐ Pending	2.00	Injury , Day Year)	28b. Time of Injury	M 2	8c. Injury Work	at ?	2	8d. Describe h			. , ,	
Division of	ten leat tor: the	Certification:	2 Accident investigations and	ot be 28e. Place	of Injury - At ho g, etc. (Specify	ome, tarm, stre			es 2□N		8f. Location (S City or Tow	Street and in, State)	Number or Ru	ural Route Nun	nber,
	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	edical C	29a. Certifier 1 Certifying (Check only one)	Physician: To the taxaminer: On the ba	sis of examinal	wledge, death tion and/or inv	occurred restigation,	at the time , in my opi	e, date and inion, deat	d place, a	and due to the o	ause(s) a	nd manner as place, and due	stated. to the cause(s	s)
	within 2 To the	ž	29b. Signature and title of certified	X	^ -		290	. License			à	29d. Date	signed (Monti	h, Day, Year)	
	((a))		•	5 7 1	V	1		D24	064		•	41	7/96		
_			30. Name and address of person with completed cause of death (Item 23a) (Type, Print)									E			
700	Sta	te	Shantha Murthy 31. Date filed (Month, Day, Year)				u., #	<i>320,</i>	uxon	Hli	I, MD	2074	<u> </u>		
	Registr	3		1 AV	Shantha Murthy, MD 6196 Oxon Hill Rd., #520, Oxon Hill, II  Date filed (Month, Day, Year)  32. Registrar's Signature										

	als and a		For State Registrar				nd / Dep		f Healtl	h and M	ental Hyg	-	06	07953
(\$)	Physic	ian	1. Decedent's Name () Greta	First, Middle, La L .		Deeniha	n				2. Date of Deat Month	Day	Year	3. Time of Death
	/Medi	cal	4a. Fecility Name (If no				111	41- 03- T-		(2)	Februai			9:45 p M
	Exami	ner		. 3		,	- C D-1-	4b. City, Tow					ity of Death	
\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	Funeral	- A see	Springbro  5. Social Security Num	ber 6.	Sex		J & Ren s. last birthday,	If Under 1 Y	ear If Und		8. Date of Birth		tgome:	ry place (State or Foreign ptry)
	Director		579-18-642	3	1□M 2 <b>X</b> F	8	8 Yrs.	Months Da	ays Hour	s Min.	(Month, Day, Dec. 30		7 Wash	ington, DC
	and		Usual Residence of De 10a. State	ocedent 0b. County		10c. (	City, Town or L	ocation						Od. Inside City Limits
	Maryi f aho	lo												1 ☐ Yes 2 🔀 No
	r 28a	Funeral Director	Maryland  10e. Street and Number	Montgon er	iery		Silver	10f. Zip Coo	de		10	g. Citizen o	f What Cour	ntry?
	th wit	alD	15101 Int	erlache	n Drive	9		20906	5			USA	A	
	tems	uner	11. Marital Status		Armed F		U.S. 13.	Was Decedent If Yes, specify (	of Hispanic Cuban, Mexi	Origin? (Spec	cify Yes or No-		ace - Americ	
36	rs afte	by F	1 ☐ Never Married 3 ☑ Widowed 4 [		1 □ Yes If Yes, G Year or	2 😿 No live		1 ☐ Yes 2 🖺				Spec	Whi	
9	72 hours after death with the Maryland natural', or items 23a or 28s-f show disal Examinat must be rotified at	ted	15	. Decedent's E	ducation		16a. Dece	dent's Usual Oc	cupation		1	6b. Kind of	Business/Inc	dustov
215	Bu "n	ple	(Specify Elementary/Seconda	onfy highest gr		) (1-40 <i>t</i> 5+)	(Give	kind of work do DO NOT use re	ne during m tired)	nost of workin	9	00.11110	20011034111	oustry
2	ygien ygien ter th	Completed			4		Te	acher A	Aide			Educa	ation	
and	be fill d oth	Be	17. Father's Name (Fir.						1		(First, Middle, M		ime)	
ž	d Mer d Mer mark	<sup>2</sup>	F. Gwynn  19a. Informant's Name				10h 14-33				. Hellm			
Maryland 21215-0036	ith an		Greta Pig			2					Route Number, Rockv			
re,	Hear item		20a. Method of Disposi	rtion		20b.		osition (Name o		Da	ite 2		· City or To	
Ē	Page nent con to the second control of the s		f Burial 2 □ C 4 □ Donation 5 [	remation 3 ☐ ☐ Other <i>(Speci</i> i	]Removal from (y)			ven Cemet		March 20		ilver	Sprin	g, Marylan
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryian Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23s or 28s-f show any injury goether traumatic avent, the Mudical Examinat must be notified at once.		21. Signature of Funer	al Service Lice	nsee	100	F2	2. Name and Ac	dress of Fai	diyns F	uneral 1	Home 1	nc.	
	20529	. 52	day	es 5	000	De Z	50	00 Unive	rsity	Blvd,	W, Sil	ver Sp	ring,	MD 20901
h			23a. Part1. Anter the c shock, or heart fa	illure. List offiny	plications that one cause on	caused he dea each line.	ith. Do not ent	er the mode of	dying, such	as cardiac or	respiratory arre	st,		Approximate Interval Between
	Physician /Medical		Immediate Cause (Fin disease or condition resulting in death)	al		diopulm		rrest						Onset and Death
	Examiner		,	- (		(or as a conse microb		sis						
		Jer	Sequentially list condit if any, leading to imme cause. Enter Underlying	ions,	b	(or as a conse								
	death certificate be executed attending physicien and dior use as the burial-transit	Examiner	that initiated events	ry	c.									
760,	e exe	EX	resulting in death) Last		Due to	(or as a conse	quence of):	_						
$\infty$	physic physic s the b	dlcal		•	_ d.									
9 XO	leath certific attending p	/Me	IF FEMALE:		23c. If yes, ou	tcome of pregr	ancy							
m	death d for L	Physician/Med	in the past 12 mor	nths?	1 Live	birth 2 Fet	aldeath 3	Ectopic pregnal Other (specify					ate of delive onth	ry Day Year
0	at the de by the a tached	hys	9 Unknown		9□ Unkn	own								
	The law requires that the te has been signed by tho age 2 should be detached.	by P	Part II. Other significan Depression	nt conditions o	ontributing to d	leath but not re	sulting in the u	nderlying cause	given in Par	rt I.	23e. Did toba	cco use con	tribute to th	e cause of death?
ecords,	equir een si bluoi	ted		, begar							1 ☐ Yes	2 🗆 No	3 🗌 Proba	ably 4 🕅 Unknown
Ö	a law law law law law law law law law la	Completed									24a. Was an autopsy	24b.	Were autop	osy findings available inpletion of cause of
I E		Con									perform	d? No	death?	
Vital	Physician: The r this certificate I ral director, pag	Be	25. Was case referred examiner?	to medical	Hospital:				0.4		Check only one	0		
ō	Phys rthis ral dii	2	1 Yes 2 No		28a. Date	Inpatient 2	ER/Outpatien 28b. Time of	1 SLI DOA	Other: XX		e 5 ☐ Residen			)
0	th. : After s funer	tlor	1. Natural 5 2 ☐ Accident	Pending investigation	(Mon	th, Day Year)	Injury		njury at Vork? □ Yes 2{		d. Describe how	injury occu	rred	
DIVISION	of or Attending after death. I Director: After In by the fune	Certification:		Could not be determined	28e. Place	of Injury - At h	ome, farm, str	eet, factory, offic			f. Location (Stre	et and Num	ber or Rural	Route Number,
5	spital or rours afte neral Dir filled in	Cert	4 _ Tromoleo		Bulla	ing, etc. <i>(Speci</i>	ry)				City or Town,	State)		
	To the Hospital of Within 24 hours af To the Funeral D completely filled in	ical	(Ollock Dill) FL	Certifying Ph Medical Exam	ysician: To the	best of my knows	owledge, death	occurred at the	time, date	and place, an	d due to the cau at the time, dat	se(s) and m	anner as sta	ated.
	To the Howithin 24 h To the Fur completely	Medi	29b. Signature and title		and man	ner stated.			ense numbe					
	F 3 5 8							296. Lice	C 2	16	7	Date sign	Month, C	Ay, Yearly
	>	1	30. Name and addr ss	of person who	completed caus	se of death (Ita	n 23a) (Tyne	Print)	20	17	/	X	0//	00
			Nasreen K					enue, #	205,	Takoma	Park, M	1D 209	12 l	
	Sta Registra		31. Date filed (Month, D		006 32.	egistrar's Sign	ature	odl)						
	TIEGISTI	11		RUL	UUU Z									

			1 - For State Registrar	· ·	epartment of Health ar Certificate of Death	nd Mental Hygier	1100 01704
ı	Physici /Medic		1. Decedent's Name (First, Middle, Last)  Dorothy P. D	uVall		2. Date of Death Month March 7	3. Time of Death 12:41P M
	Examin Funeral Director		4a. Facility Name (If not institution, give s 74 LaVale Blv  5. Social Security Number 6. Sex 220-10-7446	d 7. Age (In yrs. last birti	4b. City, Town, or Location of I LaVale  If Under 1 Year	Hrs. 8. Date of Birth	Allegany  9. Birtholace (State or Foreign)
	D	or	Usual Residence of Decedent  10a. State 10b. County  MD Allegan	10c. City, Town			10d. Inside City Limits 1 ₩ Yes 2 No
	h with the A 23a or 28a-	ai Director	10e. Street and Number 74 LaVale Blv	đ	10f. Zip Code 21502		Citizen of What Country?
36	d within 72 hours after deeth with the Maryland Jene. r then "naturel", or iteme 23a or 28e-f ehow The Madical Examiner must be notified at	by Funerai	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates:	13. Was Decedent of Hispanic Origin If Yes, specify Cuban, Mexican, F	n? (Specify Yes or No- Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White
Maryland 21215-0036	within 72 hou ene. then "nature he Mudical E	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	cation 16a.	Decedent's Usual Occupation (Give kind of work done during most o life. DO NOT use retired)  HOUSEWIFE	f working	Kind of Business/Industry  Own Home
land 2	uld be filed v fental Hygie rked other t fic event, th	To Be Co	12 17. Father's Name (First, Middle, Last) John F. Trostl	e	18. Mother's	Name (First, Middle, Maid (Lindemer	en Sumame)
Mary	s 1 and 2 should be filed f Health and Mental Hyg Item 27 ie marked othe other traumatic event,		19a. Informant's Name/Relationship (Ty) Ann Castles	Daughter 5	Mailing Address (Street and Number of Campground Rd.		
Baltimore,	permit. Peges 1 and Depertment of Healti Important: if Item 2; eny injury or other once.		20a. Method of Disposition 1 ☆ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State cemeter)	Disposition (Name of corematory or other place) et Memorial Ma	r 10 2006 (	Location - City or Town, State  Cumberland, MD
Balt	permit. Depertinon. Importion inj		21. Conature of Funeral Service License	1 Hope	22. Name and Address of Facility 1302 National of enter the mode of dying, such as ca		ral Service, PA ale, MD 21502
68760, ~	hysician and by special francial edicai Examiner	shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)  Satuential, list conditions if any, leading to immediate cause. Enter Underfying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of Due to (or as a consequence of	y edema		Interval Between Onset and Death S May S	
P.O. Box 6	death certif e ettending id for use as	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregnancy  1  Live birth 2  Fetal death  4  Pregnant at time of death  9  Unknown	3 Ectopic pregnancy 5 Other (specify)		23d. Date of delivery Month Day Year
Ś	requires that the teen signed by th hould be detache		Part II. Other significant conditions con	stributing to death but not resulting in	the underlying cause given in Part I.		o use contribute to the cause of death?
al Reco	i: The law re icete has bee r, page 2 sho	Completed				24a. Was an autopsy performed?	
Division of Vital Record	To the Hospital or Attending Physicien: The law within 24 burus eiter death.  To the Funerel Director Atter this certificate has completely filled in by the funeral director, page 2.	ation; To Be	25. Was case referred to medical examiner?  1  Yes  No H  27. Manner of Death  Qatural 5  Pending 2  Accident investigation	ospital: 1   Inpatient 2   ER/Out  28a. Date of Injury (Month, Day Year)  28b. T	patient 3 DOA Other: 4 Nursi	ng Home Residence 28d. Describe how in	
Divis	tal or Atters setter des	Certification;	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At home, far building, etc. (Specify)	m, street, factory, office	28f. Location (Street City or Town, Sta	and Number or Rural Route Number, ate)
	To the Hospital within 24 hours or To the Funerel I completely filled	edicai	(Check only 2   Medical Examir one)	sician: To the best of my knowledge, ner: On the basis of examination and and manner stated	death occurred at the time date and p Vor investigation, in my opinion, death	occurred at the time, date a	and place, and due to the cause(s)
)	o T Con	Σ	29b. Signature and title of certifier  Glorge Hann		29c. License number DO0 59 U	79 315	Nate signed (Month, Day, Year)  A (2006  Mound, MD 2 (502
	\		30. Name and address of person who co	Wil MD 975	Type, Print) Lop was	4 Campe	dand, MD 21502
	Sta Registr	_	MAR 1 5 2006	32. Registrar's Signature	ade)		

Dhyaie	an	1. Decedent's Name (First, Middle, Last				<del></del>			2. Date of De	ath		3. Time of	
Physic /Medi Examir	cal	Edna May Enso  4a. Facility Name (If not institution, give Westminster N Rehabilitation	street and number) lursing ar	nd		estm	ins	ter	March	4c.	2006 County of De Carre	1:40 eath oll	
Funeral Director		5. Social Security Number  212-20-0537  Usual Residence of Decedent	9X 7. Age (I ☐ M 2 🖾 F 86	n yrs. last birthday, Yrs.	Months		If Under a	Min.	8. Date of Bir (Month, Da Feb. 2.	th iv. <i>Year)</i> I <b>,</b> 19	9. E	Birthplace (State of Country) aryland	r Foreig
72 hours after death with the Maryland naturel', or frems 23a or 28a-1 show digal Examina munt be notified at	ctor	10a. State 10b. County  MD Baltim		Oc. City, Town or L Parkto								10d. Inside Cit	
a or 2	Dire	10e. Street and Number 2400 Mt. Carm	nel Road		10f. Zip 0	Code 1120				_	izen <i>o</i> f What S . A .	Country?	
Dop strained of Health and Merial Hygiene. Important: If item 2.2a or 28a-1 show any injury or other traumatic event, the Medical Examination and the modified at any injury or other traumatic event, the Medical Examination and the modified at any injury or other traumatic event.	d by Funeral Director	11. Marital Status  1  Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Eve Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates:	er in U.S. 13.	Was Decede If Yes, specif		panic Oric Mexican Specify:	gin? (Spe , Puerto	ecify Yes or No Rican, etc.)		14. Race - Ar Black, W	merican Indian, hite, etc. White	
al Hygiene. I other then "naturel", vant, the Medical Exe	Completed	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12)		(Give	ident's Usual e kind of work DO NOT use nemake	k done du e retired)	ion i <i>ring</i> most	t of worki	ing		ind of Busine: wn Hor		
ind Mental Hyg	To Be C	17. Father's Name (First, Middle, Last) Ross Murray				1			(First, Middle, Lene H		Sumame)		
th and 7 is my traum	1	19a. Informant's Name/Relationship (T) Patricia A. Wri							estmin				
Deprument of Health Important: If them 27 any injury or other to one.		20a. Method of Disposition  1 XBurial 2 Cremation 3 1  4 Donation 5 Other (Specify,	Removal from State	20b. Place of Disposements, cre Mt. Cam Methodi	osition (Name matory or oth	ne of her place)	M		n 10,	20c. Lo		or Town, Stete	
Deportm Importa any inju	7	amas .	fartents	. 2	2. Name and	d Address	of Facility	y J.	J. Har			Mortuary A 17349	
hysician /Medical xaminer		Immediate Cause (Final disease or condition resulting in death)	a Meta	statio	12		1		ma.			Onset and D	Journ
physician and the burial-transit	dical Examiner	Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b.  Due to (or as a c  Due to (or as a c  C.  Due to (or as a c	onsequence of).		La		Con	els			1 yr	
y the attending physician and iched for use as the burial-transit	cal	if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a c	onsequence of):  onsequence of):  oregnancy  Fetal death 3[	□Ectopic pre	egnancy		Con			23d. Date of o	,	/ear
en signed by the attending physician and be detached for use as the burial-transit	by Physician/Medical	if any, reading to intrrediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Ves 2 No	b. Due to (or as a c  c. Due to (or as a c  d. 23c. If yes, outcome of 1 1 Live birth 2 (4 Pregnant at tim 9 Unknown	onsequence of):  onsequence of):  oregnancy  Fetal death 3 { se of death 5 {	□Ectopic pre	egnancy ecify)				obacco u	Month use contribute	,	eath?
s been signed by the attending p should be detached for use as	Completed by Physician/Medical	If any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that inflated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 Who 9 Unknown  Part II. Other significant conditions con	b. Due to (or as a c  c. Due to (or as a c  d. 23c. If yes, outcome of 1 1 Live birth 2 (4 Pregnant at tim 9 Unknown	onsequence of):  onsequence of):  oregnancy  Fetal death 3 { se of death 5 {	□Ectopic pre	egnancy ecify) tuse given	in Part I.		23e. Did t 1 1 24a. Was autoj perfc 1 Yes	obacco u Yes 2 an psy primed? 2 No	Month use contribute No 3   24b. Were	Day Y to the cause of de Probably 4 □U autopsy findings a o completion of ca?	eath? Jnknov availat
this certificate has been signed by the attending pal director, page 2 should be detached for use as	To Be Completed by Physician/Medical	If any, reading to immediate cause. Enter Underlying Cause (Disease or injury that inflated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	b. Due to (or as a c  c. Due to (or as a c  d	onsequence of):  onsequence of):  oregnancy Fetal death 3 (see of death 5 (see	□Ectopic pre □ Other (special content of the conte	egnancy scify)	n in Part I.	of Death	23e, Did t 1 1 24a. Was autor	obacco u Yes 2 an posy ormed? 2 No one)	Month  See contribute  No 3   24b. Were prior to death 1  Y	Day Y to the cause of de Probably 4 U autopsy findings a o completion of ca ? es 2 No	eath? Jnknov
this certificate has been signed by the attending pal director, page 2 should be detached for use as	To Be Completed by Physician/Medical	If any, reading to immediate cause. Enter Underlying Cause (Disease or injury that inflated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	b. Due to (or as a c c. Due to (or as a c d	onsequence of):  onsequence of):  oregnancy   Fetal death   3[  ite of death   5 [  ot resulting in the other of the other	□Ectopic pre □ Other (spe- underlying call  nt 3□ DOA  of 28	egnancy scify)  Luse given  A Other: 3c. Injury a Work? 1 □ Ye	26. Place	of Death	23e. Did t  1	obacco u Yes 2 an an an any ormed? 2 No one) dence ( how injur	Month  See contribute  No 3   24b. Were prior to death 1  Y  6  Other (S) y occurred	Day Y to the cause of de Probably 4 U autopsy findings a o completion of ca ? es 2 No	eath? Inknow availab ause of
The certificate has been signed by the attending pal director, page 2 should be detached for use as	Certification: To Be Completed by Physician/Medical	If any, reading to infinediate cause. Enter Underlying Cause (Disease or injury that inflated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	b. Due to (or as a c c. Due to (or as a c d	onsequence of):  onsequence of):  oregnancy   Fetal death   3   le of death   5   lot resulting in the oreginal   28b. Time oreginal	DEctopic prediction of the control o	egnancy pcify)  Luse given  A Other:  C. Injury a Work?  1 Ye office	26. Place 4 Qui	of Death rsing Hor	23e. Did t 1 1 2 24a. Was autor 1 1 Yes 1 (Check only of the South of	obacco u Yes 2 I an psy primed? 2 No one) dence ( how injur  Street an wn. State cause(s)	Month  Ise contribute  No 3   24b. Were prior to death 1  Y  6  Other (Single y occurred)  and manner	Day Y  to the cause of de  Probably 4 \( \subseteq U \) autopsy findings a o completion of ca ? es 2 \( \subseteq No \)  Decify)  Rural Route Numb as stated.	eath? Inknow availab ause o'
trending Prysician: The law requires that the death certific death.  Stor: After this certificate has been signed by the attending pater (the funeral director, page 2 should be detached for use as	To Be Completed by Physician/Medical	If any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	b. Due to (or as a c c. Due to (or as a c d	onsequence of):  onsequence of):  oregnancy   Fetal death   3   le of death   5   lot resulting in the oreginal   28b. Time oreginal	DEctopic prediction of the control o	egnancy scify)  Luse given  A Other: Work? 1 Ye office  At the time in my opin	26. Place 4 Qui	of Death rsing Hor	23e. Did t  1 24a. Was autor part of the second of the sec	obacco u Yes 2 an psy primed? 2 No one) dence ( how injur  Street an wm, State  cause(s) date and 29d, Dat	Month  Ise contribute  Alo 3    24b. Were prior to death 1   Y  6   Other (S) y occurred  d Number or in the prior of place, and designed (Monte)	Day Y  to the cause of de  Probably 4 U  autopsy findings a  o completion of ca ? es 2 No  Decify)  Rural Route Numb as stated. ue to the cause(s)	eath? Jnknow availab ause o

State Registrar

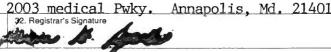
DHMH 17 Rev 1/2001

MAR 0 1 2006

MD

Paula Ann Radon,

31. Date filed (Month, Day, Year)



			1 - For State Registrar	State of Maryla		artment of I		ental Hygier	6	07958
			1. Decedent's Name (First, Middle, La.	st)			2	2. Date of Death	Day Year	3. Time of Death
	Physici /Medi		Cecil Ottlee	Echard			Į.	ebruary	28 2006	1705PM
	Examir		4a. Facility Name (If not institution, give	street and number)	11	4b. City, Town, o	or Location of Death		4c. County of Deet	
				reneval Ho	spital	Can	nbndge		Dorch	ester
	Funeral		5. Social Security Number 6. S	TH SME	s/last birthday	Months Days	If Under 24 Hrs. 8	3. Date of Birth (Month, Day, Yea	9. Birt	hplace (State or Foreign
	Director		214-07-8448	9!	5 Yrs.			Jan. 29,		aryland
	and		Usuel Residence of Decedent  10a. State 10b. County	10c. C	City, Town or L	ocation				10d. Inside City Limits
5	Maryland -f show	ō	MD Dorch	ester		Cami	bridge			1 Yes 2 No
R		rect	10e. Street and Number			10f. Zip Code		10g. 6	Citizen of What Co	untry?
2	72 hours after death with the neturel', or Items 23a or 28a ifeal Examinational be mult	Funeral Director	204 Brohawn Ave	•			21613		USA	,
P	er death	Jera	11. Marital Status	12. Was Decedent Ever in	U.S. 13.	Was Decedent of I	Hispanic Origin? (Spec ean, Mexican, Puerto Ri	ify Yes or No-	14. Race - Ame	
9	after or Ite		1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 ☑No				ican, etc.)	Black, White	
8	rel', c	1 by	3 ⊠Widowed 4 □ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 💢 No	Specify:		Specify: \	white
5-0	72 h	Completed	15. Decedent's Ed (Specify only highest gra	tucation de completed)	(Give	dent's Usual Occup kind of work done	during most of working	16b.	Kind of Business/	Industry
21	d within giene. Ir then "	mpi	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retire	nd)			
2	L	S	8			nurses			tate hosp	pital
and	9 g 2 5	Be	17. Father's Name (First, Middle, Last)				18. Mother's Name (		en Sumame)	
3	2 should be and Mental Is marked or raumatic ever	은	Ira Jones	W	400.00.00		Lucy Wi			
Maryland 21215-0036	s 1 and 2 should f Health and Mer item 27 Is marke other traumatic	1 1	19a. Informant's Name/Relationship (				and Number or Rural			(ip Code)
	of Health item 27		Terry Hogan  20a. Method of Disposition	great niece			s Dr., Pres		21655 Location - City or	Tourn State
Jor	0 0 = 5		1 ⊠ Burial 2 ☐ Cremation 3 ☐			osition (Name of matory or other pla		200.		
Baltimore,	nit. Pa artmen ortent: injury e.		* 4 □ Donation 5 □ Other (Specific			Market Ce	em. 3/4/0			arket, MD
Bal	permit. Pag Department Importent: I any injury c		21. Signature of Funeral Service Licer	300			st St., Can			
	402 % 6		23a. Part1. If ter the disease, or com	Signations that assessed the de-					בוסוב כעיי	Approximate
1	Physician		shock, of heart failure. List only Immediate Cause (Final disease or condition resulting in death)	one cause on each line.	DS is	ter the mode of dyll	ng, such as cardiac or	respiratory arrest,		Interval Between Opset and Death
	/Medical Examiner		Tesulting in deatiny	Due to (or as a conse	equence of):					
		<u></u>	Sequentially list conditions,	b. Due to (or as a conse	equence of):					
	red	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,					
,	be executed sician and burial-transit	ха	that initiated events resulting in death) Last	Due to (or as a conse	equence of):					
160	ate be only sicial he buri	cail	(	d						
687	certificate be execut nding physician and use as the burial-trar	ed		, 4.						
Box	death certifica attending ph d for use as th	Physician/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregr					23d. Date of deli	very
ă	death	cial	in the past 12 month?	1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of		□Ectopic pregnanc □ Other (specify) _	у		Month	Day Year
P.O.	that the de ned by the a detached t	hysi	9 Unknown	9□ Unknown				ú.		
	requires that the een signed by th nould be detache	by P	Part II. Other significant conditions of	ontributing to death but not re	sulting in the u	inderlying cause giv	ven in Part I	23e. Did tobacc	use contribute to	the cause of death?
r Sp	quire n sig uld b	pe pe	HICIAL FIDE.	Ation, Co	1505+	ive her	aH JAILUI	1 ☐ Yes	2  3 □ Pr	obably 4 DUnknown
00	> 00	iete	Danceatiti.	S Reual	U(a:	lure.	A -	24a. Was an	24b. Were au	topsy findings available
Vital Records,	0 4 0	Completed	50101	Stenosis	1 - 11			autopsy performed?	death?	completion of cause of
ta	ician: Th certificate rector, pag	C	25. Was cas referred to medical	31640313			26. Place of Death	Check only and	√6 1 □ Yes	21 00
>	Physician: this certific al director.	0 8	examiners	Hospital: 1 Vice tient 2	☐ ER/Outpatie	nt 3□ DOA Oth	200	5 ☐ Residence	6 □Other (Spec	rifu)
Division of		n: T	27. Manner of Sath	28a. Date of Injury (Month, Day Year)	28b. Time o		Action to the second se	d. Describe how in		nty)
ion	Attending I r death. sctor: After by the funer	atio	1 Natural 5 ☐ Pending 2 ☐ Accident investigation		Injury		Yes 2 No			
<u>Vis</u>	Atte	ific	3 ☐ Suicide 6 ☐ Could not be determined	288. Place of Injury - At I	home, farm, st	reet, factory, office	28	f. Location (Street		ral Route Number,
	s afte	Certification:	- Nonneide	building, etc. (Spec	any)		Į,	City or Town, Sta	110/	
	bour hour naere ly fille	sal (	29a. Certifier Certifying Ph	ysicien: To the best of my kn	nowledge, deal	h occurred at the til	me, date and place, an	d due to the cause	(s) and manner as	stated.
	To the Hospitel or Attentwithin 24 hours after deatl To the Funerel Director:	ledical	one) 2 Medicel Exen	niner: On the basis of examination and manner stated.	ation and/or in	ivestigation, in my o	opinion, death occurred	at the time, date a	nd place, and due	to the cause(s)
	To the Hospitel or Attendi within 24 hours after death. To the Funerel Director; A completely filled in by the fu	Σ	29b. Signature and tyle of certifier	1/	$\wedge$	29c. Licens	se number	29d. E	ete signed (Monti	n, Day, Year)
			1000 a	1 pon V.	U.	1	77610	3/	2106	
			30. ame and ddress of person who	eted cause of death (Ite	em 23a) (Type,	Print)		> /	1	
			14015 A.	1 IVARR	D.O	,	100 K	) (Anb)	E 57	No.
1	Sta		31. Date filed (Month, Day, Year)	32. Registar's Sign	nature	A sti				
14	Registi	ar.	INDUSTRY U	J. Lucio	0	A STATE OF				

State of Maryland / Department of Health and Mental Hygiene 1- State Registrar Amend #26 per/fh 03-03-2006 Commissionate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death February 26, 2006 **Physician** Mary Eyler 3:35A M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Lorien of Mt. Airy Mt. Airy Carrol1 If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day Year) | 9. Birthplace (State of Month, Day Ye Social Security Number 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign 214-10-4324 1 ☐ M 2 😿 F 90 Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f ehow ed other then "natural", or Items 23a or 28a-f ehovevent, the Medical Examinar must be notified at Maryland Director Frederick T¥TYes 2 □ No Mt. Airv 10e. Street and Number 10f. Zip Code 10g. Citizen of Whal Country? 603 E. Ridgeville Blvd 21771 USA death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 Married ☐Yes 2 No Maryland 21215-0036 ģ 1 ☐ Yes 21 No Specify Specify: White 3 Widowed 4 □ Divorced Year or Dates Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be pe and Mental 27 le marked o traumatic eve Pages 1 and 2 should nent of Health and Men Joseph V.Hartman Mary Grace Ray 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) partment of Health a portant: If item 27 le Cindy King/ Daughter 26300 Purdum Road Damascus, MD 20872 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Slate 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Mout Olivet 03/02/2006 Frederick, MD 21. Signature of Funeral Service Licenses Depart Import eny Inj once. 22. Name and Address of Facility 8 East Ridgeville Blvd, Mt. Airy, MD 21771 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed the burial-transit and physician Physician/Medical disense use as t attending for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) signed by the a Ö م significant conditions contributing to death but not resulting in the underlying cause given in Part J. 23e. Did tobacco use contribute to the cause of death? ģ certificate has been si rector, page 2 should 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe of Vital 2 No 1 ☐ Yes 1 ☐ Yes To the Hospital or Attending Physicien: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director. 25. Was case referred to medical 26. Place of Death | Check only one Other: 4 Nursing Home Certification: To 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Mesidence 6 □Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 1 Natural 5 Pending 2 Accident investigation М 1 ☐Yes 2 ☐No 3 🗀 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge death occurred at the time, date and place, and due to the dauss(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature 29c. License number 29d. Date signed (Month, Day, Year) and address person who completed cause of wath (Item 23a) (Type, Print) House Ave, O-1, Frenceick, MO 21701 31. Date filed (Month, Day, Year) 32. Distrar's Signature State MAR 0 3 2006

DHMH 17 Rev 1/2001

Registrar

DHMH 17 Rev 1/2001

Registrar

MAR 0 1 2006

			1 - For State of Maryland / Dep	artment of Health and Mertificate of Death	Mental Hygie	2006	07961					
			Decedent's Name (First, Middle, Last)	7	2. Date of Death Month	Day Year	3. Time of Death					
	Physicia /Medic		Harriet Louise Ford		February	25 2006	11:20 A <sup>M</sup>					
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Dear						
			4226 Kinmount Road	Lanham		Prince G						
	Funeral		5. Social Security Number 6. Sex 1 □ M 2 ☒ F 7. Age (In yrs. last birthday	If Under 1 Year   If Under 24 Hrs.   Months   Days   Hours   Min.	8. Date of Birth (Month, Day, Ye	9. Bin Co	hplace (State or Foreign buntry)					
	Director		577-58-3608 G1 Yrs.		Nov. 6,	1944   Oh	TO					
	yland 10W		10a. State 10b. County 10c. City, Town or I	ocation			10d. Inside City Limits					
	a-f st	to	MD Prince George's Lanh	am			1 ☐ Yes 2 ☑ No					
	or 28	Funeral Director	10e. Street and Number	10f. Zip Code	10g.	Citizen of What Co	ountry?					
	ath w	la	4226 Kinmount Road	20706		USA						
	er de Items	nue		Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit						
36	rs aft	by F	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 M No If Yes, Give 3 ☐ Widowed 4 ☐ Voircoed Year or Dates:	1 ☐ Yes 2X No Specify:		Specify: R1	ack					
21215-0036	72 hours after death with the Maryland natural; or Items 23a or 28a-f show neal Exam he must be rediffed a	ted		edent's Usual Occupation	166	. Kind of Business/						
215	within 7 ene. than "n the Wedi	ple	(Specify only highest grade completed)  (Giv   Elementary/Secondary (0·12)   College (1-4or 5+)	e kind of work done during most of work DO NOT use retired)								
7	filed wil Hygien thar th	Completed	5+	Principal		Public Sc	hool					
Maryland	be filed at Hygid of other event, Il	Be	17. Father's Name (First, Middle, Last)		e (First, Middle, Maid	,						
2	2 should be and Mental Is markad c	၉	Robert D. Goodloe  19a. Informant's Name/Relationship (Type, Print)  19b. Mai	ing Address (Street and Number or Run	e R. Young		Zin Codol					
<u>≅</u>	d 2 sl th and 7 Is r traur				nham, MD.	20706	Lip Code)					
	is 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene. Item 27 is marked other tran "natural", or Items 28a or 28a-f show them 27 is marked other transmitter or other transmite event. The Medical Examination will be rediffed at		20a Method of Disposition 20b. Place of Disp	osition (Name of	the state of the s	Location - City or	Town, State					
9	Pages ent of nt: If I		1 Li Buriai 2 Mi Cremation 3 Li Hemovai from State	itan Crematory 02/	27/2006 7	Mlevandri	a = VA					
altimore,	permit. Pages 'Department of H Important: If Ite any injury or ot				all Funera		C VII.					
m	permi Depa Impo any id		Chrism Powell	6512 NW Crain Hwy.	Bowie,		15					
			23a. Part 1. Enter the disease, or complications that caused the death. Do not el shock, or heart failure. List only one cause on each line.	nter the mode of dying, such as cardiac	or respiratory arrest,		Approximate Interval Between					
B	r nysician		Immediate Cause (Final disease or condition	leing to	men		Onset and Death					
	/Medical Examiner		resulting in death)  Due to (or as a consequence of):	J								
	Examine,		Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):									
	nted Insit	mine	Cause (Disease or injury									
Ć.	be executed sician and burial-transit	Exami	that initiated events resulting in death) Last c. Due to (or as a consequence of):									
8760,	zate be ex physician the buria	dlcal	d									
9	death certificate e attending phys id for usa as the	ě.	IF FEMALE:									
Вох	eath certific attending p	ian/	23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3	□Ectopic pregnancy		23d. Date of dei Month	ivery Day Year					
o o		Physician/M	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 5 ☐ Unknown	Other (specify)								
σ.	that the sad by detac		Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacc	o use contribute to	the cause of death?					
ds,	requires that the een sign <b>a</b> d by th hould be detache	d by	Breat Concer	1991	1 🗆 Yes	2 No 3 Pr	obably 4 Unknown					
00	w requir	lete			24a. Was an	24b. Were au	itopsy findings available					
Re	The law ate has b page 2 sl	Completed			autopsy performed 1 Yes 2	death?	completion of cause of					
Vital Records,		O	25. Was case referred to medical	26. Place of Deat	h (Check only one)	10103	20.00					
of V	d d	To B	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient	ent 3 DOA Other: 4 Nursing Ho	ome 5 Mesidence	e 6 □Other (Spe	cify)					
		ii o	27. Manne of Death 28a. Date of Injury 28b. Time (Month, Day Year) 28b. Time (nonth, Day Year) 28b. Time	Work?	28d. Describe how it	njury occurred						
Sio	en or:	icat	2 Accident investigation 3 Suicide 6 Could not be	M 1 Yes 2 No	28f. Location (Street	t and Number or Pi	umi Poudo Alumbar					
Division	of or Attendate death Director:	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	treet, ractory, office	City or Town, Si		nai Noute Number,					
_	To the Hospital or Att. Within 24 hours after de To the Funeral Directo Completely filled in by the		29a. Certifier 1 Certifying Physician: To the best of my knowledge, dea									
	the Ho hin 24 h the Fu npletely	edical	(Check only one) 2 ☐ Medical Examiner: On the basis of examination and/or and manner stated.	nvestigation, in my opinion, death occur	red at the time, date	and place, and due	to the cause(s)					
	To the state of th	ž	29b. Signature and title of contifier	29c. License number	29d.	Date signed (Mont	h, Day, Year)					
)	15)		Droing J. Dissun	9 44 3	× 8	4627	1006 -					
	GOP		30. Name and address of person who completed cause of death (Item 23a) (Type		2.							
	Sta	to.	31. Date filed (Month, Day, Year) 32. Registrar's Signature	nse Highway Annar	polis, MD.	21401						
	Registr	- 1	FEB 2 8 2006 Bleave & species	FEB 2 8 2006 32. Registrar's Signature								

			For State Registrar	State of Ma	•	epartment of Certificate			Reg	ne 0 06	07962
* *	Physici	an	1. Decedent's Name (First, Middle, Last)  Ernest R. Godda					1	Date of Death Month	Day Yea	3. Time of Death
E	/Medic Examin	al	4a. Facility Name (If not institution, give	<del>-</del>		4b. City, Tov	n, or Location o		ebruary	28, 200 4c. County of De	
<b>→</b>	Examili	EI	14 Glen Avenue			Aı	napolis			Anne A	
**	Funeral Director		214-03-1000	7. Age	(In yrs. last birt	hday) If Under 1 Y Months D	ear If Under 2 lys Hours	Min.	Date of Birth Month, Day, Y 11y 15,	9. E 1913 M	Birthplace (State or Foreign Country) aryland
	ehow	٦̈́	Usual Residence of Decedent  10a. State 10b. County  Maryland Anne Aru	ındel	10c. City, Town		napolis	5			10d. Inside City Limits 1    Yes 2 No
	3a or 28a-f	Il Director	10e. Street and Number 14 Glen Avenue			10f. Zip Co	21401		10g	Citizen of What	Country?
USP	itled within 72 hours after death with the Maryland Hygiene. ther then "natural", or iteme 23s or 28s-f ehow int, the Modical Exerciment the colified at	by Funeral	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☒ Widowed 4 ☐ Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		13. Was Decedent If Yes, specify		gin? (Specify , Puerto Rica	Yes or No- n, etc.)	14. Race - A Black, W Specify:	merican Indian, hite, etc. White
9500-612	vithin 72 ho ne. hen "natur e Madical	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)			Decedent's Usual O (Give kind of work a life. DO NOT use n	one during most etired)		16	b. Kind of Busine We1	ss/Industry ding
and 2	8 m 8	Be	10 17. Father's Name (First, Middle, Last) Ernest R. Goddar	d, Sr.			18. Mothe		_	iden Sumame)	
Maryland	d 2 shouth and M	T <sub>O</sub>	19a. Informant's Name/Relationship (T) Ernest R. Goddar			Mailing Address (Si					e, Zip Code) 21401
Baltimore,	permit. Pages 1 an Department of Heali Important: if item 2 eny injury or other 2005.		20a. Method of Disposition  120 Burial 2 □ Cremation 3 □ F  4 □ Donation 5 □ Other (Specify)		cemeter	Disposition (Name in y, crematory or other	place)	Date 3/3/20	006 A	-	, Maryland
Balt	permit. Departr Importa eny inji		21. Signatur Coneral Service Licens	, delle	Per	147 Duke	of Glou	ıcesteı	st.,	Annapoli	ral Home s, MD 21401
# P.	Physician		23a. Part1. Enter the disease, or comp shock, or heart failure. List only o Immediate Cause (Final disease or condition	ne cause on each line	erebra	1 Vasculu			spiratory arres	t.	Approximate Interval Between Onset and Death  / M - E A
	/Medical Examiner		resulting in death)	Due to (or as a	consequence	of): epsis					Iweek
	t Insit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a							
58760,	icate be executed physicien and s the burial-transit	edical Exa	that initiated events resulting in death) Last	Due to (or as a	consequence	of):					
			IEEE MALE.								
O. Box	at the death certific by the attending pi	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at t	2 Fetal death	3 ☐ Ectopic pregr 5 ☐ Other (special				23d. Date of Month	delivery Day Year
مـ	as thi	þ	Part II. Other significant conditions co	ntributing to death bu	t not resulting in	n The underlying caus	e given in Part I.				e to the cause of death?  Probably 4 @Unknown
Division of Vital Records,	ysicien: The taw requirensis certificate hes been si director, page 2 should I	Completed							24a. Was an autopsy performe	prior death	autopsy findings available to completion of cause of 17 fes 2DNo
Ta Ta		BeC	25. Was case referred to medical examiner?						heck only one		
<u>o</u>	Physic this co	2	1 Yes 2 No	Hospital: 1 _ Inpatier 28a. Date of Injur	1 2 ER/Ou					ce 6 Other (S	Specify)
50	th. th. After t	tlon	1 ☐Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day	Year)	njury M	injury at Work? 1 ☐ Yes 2 ☐		200000	injury occurred	
Divis	al or Attending Physician: s after death. il Director: After this certifica id in by the funeral director. I	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injubulding, etc	ry - At home, fa . (Specify)	rm, street, factory, o	fice	28f.	Location (Stre City or Town,	et and Number of State)	Rural Route Number,
	To the Hospital o within 24 hours aff To the Funeral Di completely filled in	Medical	(Check only 2 Medical Exam	vsician: To the best of iner: On the basis of and manner state	examination an	d/or investigation, in	my opinion, dea		it the time, dat	e and place, and	due to the cause(s)
)	To t Withi To t	Σ	29b. Signature applittle of certifier	15			cense number	9		1. Date signed (M 66. 28	
			30. Name and address of person who come the same M9 17		(Type, Print)	100 07	r ~	ite e	201 A	napolis, AD	
2	St Regist	ate rar	31. Date filed (Month, Day, Year) MAR 0 1 200	6 Registra	r's Signature	book					

			1 - For State of Maryland / De Registrer	epartment of Certificate o		nd Mental	Hygien	6	07963
2	Physicia	an	Decedent's Name (First, Middle, Last)			2. Date Mon	of Death th Da	ay Year	3. Time of Death
3	/Medic		Mary E Grazioso			9		0_0_	
	Examin	er	4a. Facility Name (If not institution, give street and number)	4b. City, Town	n, or Location of	Death		C. County of Deal	
35	Funeral	100	5. Social Security Number 6. Sex 7. Age (In yrs. last birthe	(ay) If Under 1 Year	ar If Under 2		of Birth	9. Bin	hplace (State or Foreign
	Director		126-205098 1□M 2K□F 89 Yr	s. Months Day	ys Hours	Min. 117	18/191	6 Nev	v Zork
	pug *		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town of	r Location					10d. Inside City Limits
	daryla f ebo	ō	North Wake Apex	- Looution					1 ☐ Yes 2 ☐ XNo
	28a-	reci	Carolina  10e. Street and Number	10f. Zip Code	9		10g. C	itizen of What Co	ountry?
	th with	Funeral Director	4608 Holybrook Drive	275	539			USA	
	r dea	ıner	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent o	of Hispanic Origi Juban, Mexican,	in? (Specify Yes Puerto Rican, et	or No-	14. Race - Ame Black, Whit	
30	filed within 72 hours after death with the Maryland Hygiene. sther then "naturel", or Iteme 23e or 28e-f ehow int, the Modest Examiner mat be notified at	by Fi	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 【XXNo If Yes, Give 3 【XXWidowed 4 ☐ Divorced Year or Dates:	1 ☐ Yes 2 🕱 N				Specify:	white
3	2 hou	ted	15 Decedent's Education 16a D	ecedent's Usual Occ	cupation		16b. H	Kind of Business	Industry
21215-0036	thin 7.	ple	(Specify only highest grade completed) (CELEMENTS)  Elementary/Secondary (0-12) College (1-4or 5+)	Give kind of work dor fe. DO NOT use reti	ne during most ( rired)	of working			
	i filed within i Hygiene. other then	Completed		cretary				ealthCar	:e
and	0 = 0 >	Be	17. Father's Name (First, Middle, Last)  Thomas Bertles			's Name <i>(First, M</i> .zabeth			
Maryland	should be nd Menta marked umatic ev	٢		lailing Address (Stre					Zip Code)
	and 2 sealth ar m 27 is			08 Holybr					
ore,	一工る中		20a. Method of Disposition  1 Derivate 2 X Cremation 3 Demoval from State  20b. Place of Disposition	isposition (Name of crematory or other p	place)	Date	20c. L	ocation - City or	Town, State
Ĕ	Pages ment of lent: If it		4 □ Donation 5 □ Other (Specify) Sal.isbt	ry Cremat	cory 2	2/28/06	Sa	lisbury	MD
Baltimore,	permit. Pag Department Importent: I eny injury o		21. Signature of Funeral Service Ligensee	Holloway 501 Snow	dress of Facility 7 Funera 7 Hill F	al Home Rd., Sal	Profes isbury	sional A	Association 804
0	Age of		23a. Part 1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.				•		Approximate Interval Between
žį.	Physician		Immediate Cause (Final disease or condition resulting in death)	enal (	Ell	Coxil	noma	<u></u>	Onset and Death
	/Medical Examiner		Due to (or as a consequence of)	;					
夜	Silverine B	e	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	:					
	cuted	Examiner	that initiated events						
/60,	ate be executed hysician and the burial-transit		resulting in death) Last Due to (or as a consequence of)						
$\infty$	death certificate be executed e attending physician and id for use as the burial-transit	dicai	d						
0 X	leath certific attending p	Physician/Med	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy					23d. Date of del	iverv
ROX	death e atter d for u	iciar	in the past 12 months?  1 Yes 18 No. 4 Pregnant at time of death	3 ☐ Ectopic pregnar 5 ☐ Other (specify)				Month	Day Year
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	law requires that lhe as been signed by th 2 should be detache	Ď	Part II. Other significant conditions contributing to death but not resulting in the	e underlying cause	given in Part I.	23e		- 1	the cause of death?
ecords,	w require been si	eted					1 Yes 2	2 <b>→</b> 4₀ 3 □ Pr	obably 4 Unknown
ž	0 5 0	Completed				24a	. Was an autopsy performed?	24b. Were au prior to death?	topsy findings available completion of cause of
Vital	icien: Th certificate rector, pag	င္ပ	25. Was case referred to medical		00 Di	1 🗆	Yes 2 N	o 1 ☐ Yes	21 40
	ysicien: is certific director,	To B	examiner?  1 □ Yes No Hospital: 1 Impatient 2 □ ER/Outp.	atient 3 DOA	Othor	of Death (Check		6 ☐ Other (Spe	city)
o u	ding Ph h. After th funeral		27. Manner of Death 28a. Date of Injury 28b. Time (Month, Day Year) Injury 1	ne of 28c. In			cribe how inju		
<u>                                      </u>	eath. or: Al	catic	2 Accident investigation 3 Suicide 6 Could not be		☐ Yes 2 ☐ N	0			
DIVISION	or Att	Certification:	4 Homicide determined 28e. Place of Injury - At home, farm building, etc. (Specify)	, street, factory, offic	ce		ition (Street a or Town, Stat		ural Route Number,
	To the Hospitel or Attending Physicien: within 24 hours after death.  To the Funerel Director: After this certifical completely filled in by the funeral director.	Medical Co	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, or the basis of examination and/or and manner stated.	leath occurred at the	e time, date and ny opinion, death	place, and due occurred at the	to the cause(s	s) and manner as nd place, and due	stated. to the cause(s)
	To the To the To the Complet	Me	29b. Signature and title of certifier	29c. Lice	ense number		29d. Da	ate signed (Mont	h, Day, Year)
)	18		COCCET, MD	2	260	278	0	7-28-	n, Day, Year) O6 10 21862
	20		30. Name and address of person who completed cause of death (Item 23a) (Ty	pe, Print)	Roy	1723	Si	ich 1	1021862
100	Sta	te	31. Date filed (Month, Day, Year) 32. Aggistrar's Signature		~~~		001/	<del>1</del> ), /	
	Registr	ar	MAR 0 1 2006						
DH	MH 17 Day 1/20	201		A					

			1 - For State Registrar	State o	f Marylan		artment rtificate			ind M		giene Reg. No.	006	0796	
	Physici /Medio Examir	al	LETHA  4a. Facility Name (If not institution, g DOCTORS HOSPITA)	M.	HOLLC	MAN	4b. City, To Lanh		ocation of	f Death	2. Date of De. Month	4c.	County of De	3. Time of De 10,36 auth GEORGE'S	
	Funeral Director			Sex 1☐M 2KSF	7. Age (In yrs. 94	last birthday) Yrs.	If Under 1 Months [	Year Days	If Under 2 Hours	24 Hrs. Min.	8. Date of Birt (Month, Da FEBRUAF	h y, Year) XY 8	9.8 1912 I	irthplace (State or Fo Country) NORTH CARC	oreign )LIN
Baitimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Deportment of Health and Mental Hygiene. Important: If item 27 ie marked other then "neturel", or Iteme 23a or 28a-f ehow any injury or other treumatic event, the Medical Event or must be multified at once.	To Be Completed by Funeral Director	10e. Street and Number  3704 BASKERVILLE  11. Marital Status  1 Never Married 2 Married 3 Midowed 4 Divorced  15. Decedent's (Specify only highest of the company) Secondary (0-12)  12th  17. Father's Name (First, Middle, La	12. Was Deck Armed Fic 1 Yes, Git Yes,	Sedent Ever in Unroes? 2 MNo reates:	16a. Decec (Give life. SHOR 19b. Mailin 3704	ELLVII  10f. Zip Co 20  Was Deceder if Yes, specify 1 Yes 2  dent's Usual conditions TORDE  g Address (S BASKER sition (Name natory or othe CEMET) Name and A	Tode  721 Tot of Hissy Cuban, Cuban, No  Occupation of the Company	Specify: ion ring most OOK I8. Mother MAGG of Number LE DR	of working of some of the some	(First, Middle, JONES Route Numbe MITCHE) ate DO6 B. JEN	U 16b. Kin Pl Maiden : or, City or LLVII 20c. Loc	Black, W: Specify: d of Busines RIVATE Sumame) Town, State LLE, MA cation - City of OVER, N FUNER	merican Indian, nite, etc.  BLACK ss/Industry	□ No
Division of vital necords, P.O. Box 66/60,	To the Hospitel or Attending Physician: The law requires that the death certificate be executed by Mithin 24 hours after death.  To the Funerel Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit or property.	Medical Certification: To Be Completed by Physician/Medical Examiner	29b. Signature and title of certifie	b. Due to b. Due to c. Due to d.  23c. If yes, out 1 Live b 4 Pregn 9 Unknow contributing to de contributing to de d.  28a. Date (Monto) be d.  28a. Place building contribution to the be and mann	or as a consequence of pregnalisth 2 Fetal and at time of down  ath but not result of Injury - At hong, etc. (Specify east of my known early stated).	uence of):  uence	Ectopic pregion of the control of th	nancy ify) se given Other: Injury a Work? 1 Ye office the time, my opin	in Part I.  26. Place -  4 Nurrent  to ss 2 N	of Death rising Hom lo 21 d place, and hoccurred	23e. Did to  1 Yes  24a. Was: autop 1 Yes  (Check only or e 5 Resid Bd. Describe h  Bt. Location (S  City or Tow and due to the or d at the time, or	an symmed? 2200 No ine)  lence 6 and injury  cause(s) a date and in 229d. Date	24b. Were prior to death 1 Ye  Other (Sp. occurred  Number or it oblace, and disigned (Moi	Day Year to the cause of death Probably 4 Onkr autopsy findings avai o completion of cause as 30 No necity)	r h? nown
NATURE .	Sta Registr	_	30. Name and address of person who are filed (Month, Day, Year)  MAR 0 1 200	Cholly 32. R	egistrar's Signa	cad ,	# 2	20	, 8	OW	ie-	MS	1-21	0716.	

			1 - State Registrar	State of Maryla		artment of H			iene •g. No. 0 0 6	07965			
a.	Physici	_	Decedent's Name (First, Middle, Last)     D.Wal.	J. I	Lidson			2. Date of Deal Month Februar	Day Year	3. Time of Death 23:03 M			
	/Medic Examin	-	4a. Facility Name (If not institution, give str	eet and number)		4b. City, Town, or	Location of Deal		4c. County of Dea				
			Anne Arundel Medical (			-	polis	100 (000	Ame Arun				
1	Funeral Director		5//-/8-9100	7. Age (In yr	s. last birthday) 49 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min		, 1956 Wast	thplace (State or Foreign buntry)			
	land w		Usuat Residence of Decedent  10a. State 10b. County	10c. 0	City, Town or Lo	ocation				10d. Inside City Limits			
	a-f sh	ctor	Maryland Anne Arundel			Cro	wnsville			11€Nyes 2 □ No			
	h with th	ai Dire	10e. Street and Number 1247 Bacon Ridge Road	d		10f. Zip Code	21032	1	0g. Citizen of What Co U.S.A.	ountry?			
036	nit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland artiment of Health and Mental Hyglene. ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, it a Macinal Examinational perceiting at the profiled at the perceiting of the continuous perceits and the perceiting at th	by Funeral Director	11. Maritat Status 12 1 Never Married 2 Marned 3 Widowed 4 Divorced	Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates:		Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 X No	spanic Origin? (S n, Mexican, Puer Specify:	Specify Yes or No- to Rican, etc.)	14. Race - Ame Black, Whil Specify: B	te, etc.			
215-0	nin 72 ho n *natura Medical	Completed	15. Decedent's Educa (Specify only highest grade of Elementary/Secondary (0-12)	ution completed) College (1-4or 5+)	(Give	dent's Usual Occupa kind of work done of DO NOT use retired	during most of wo		16b. Kind of Business	/Industry			
212	giene giene er ths	Com	12th grade			oreman			W.A.S.A.				
land	should be file and Mental Hy marked oth umatic event	To Be (	17. Father's Name (First, Middle, Last)  Elvert J. H.				me (First, Middle, i ertha Green						
	nd 2 shoulth and N		19a. Informant's Name/Relationship (Type Ms. Bertha M. Hudson (N			-			, City or Town, State, Land 20774	Zip Code)			
	es 1 ar of Hea fitem r other		20a. Method of Disposition  XXS Burial 2 ☐ Cremation 3 ☐ Rei		Place of Dispo	osition (Name of matory or other place	Date n 3, 2006	20c. Location - City or					
Ĕ	Pag tment tant: h		* 4 □ Donation 5 □ Other (Specify)	Ha	Harmony Memorial Park				Landover, Marylan				
Ba	permit. Pages 1 and 2 Department of Health a Important: If item 27 li sny injury or other tra 20028.		21. Signature of Funeral Service Licensee	Leisar		2. Name and Addres 339 <b>Hunt</b> Pla			eral Hone, In D.C. 20019	r.			
E	Physician /Medical Examiner but street per executed but street in the partial francial	cal Examiner	23a. Park. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, growth of the cause (Finat disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):										
P.O. Box 68	ath certif ittending or use a	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	c. If yes, outcome of preg 1 Live birth 2 Fe 4 Pregnant at time of 9 Unknown	tal death 3	□Ectopic pregnancy □ Other (specify)			23d. Date of de Month	livery Day Year			
	uires that the de signed by the a d be detached f	by	Part II. Other significant conditions contri	ributing to death but not r	esulting in the u	inderlying cause give	23e. Did to	o the cause of death? robably 4 DUnknown					
Division of Vital Records,	ne law requir has been si ge 2 should l	Completed	severe bull		24a. Was a autop:	sy prior to med? death?							
tal	ician: The lav certificate has rector, page 2	Be Co	25. Was case referred to medical	al fullure	2		26. Place of De	1 ☐ Yes eath (Check only or		s 2LANO			
<u>&gt;</u>	Physici this cer al direc	ToB	examiner? 1 Yes 2 No Ho		☐ ER/Outpatie		4 🗀 IADI SILIĞ	-	me 5 Residence 6 Other (Specity)				
o uo	Attending Physician: If death. ector: After this certific by the funeral director.		27. Manner of Death  1 □ Natural 5 □ Pending 2 □ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	Work	yat k? Yes 2 □ No	28d. Describe h	ow injury occurred				
Divis	= 5 # 6	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	reet, factory, office		28f. Location (S City or Tow	l (Street and Number or Rural Route Number, own, State)						
	To the Hospital or within 24 hours after To the Funeral Dir completely filled in	edicai (		cian: To the best of my ker: On the basis of exami and manner stated.									
	To th within To th compl	Me	29b. Signature and title of certifier	29c. License		2	29d. Date signed (Month, Day, Year)						
			+4//ele	you my			4804		2-24-	,			
1	5)		30. Name and address of person who com	Perender (II	em 23a) (Type,	Print) A A	me	Auncy	eles Md	21461			
	Sta Regist		31. Date filed (Month, Day, Year) MAR 0 1 2006	32. Registrar's Sig	nature	B		0					

			1 - For State Registrar	State of	Maryland	-	artmer rtificat			and M		giene	1116	6	079	66	
	District	<i>a</i> .	1. Decedent's Name (First, Middle, Las	(1)							2. Date of De. Month			Year	3. Time	of Death	
	Physici /Medic		Effie Lee Harris	5							02	23		06	4:02	2 A M	
	Examin	er	4a. Facility Name (If not institution, give	street and numb	er)		4b. City,	Town, or	Location o	of Death			County of				
	4.4	1860 P.	Southern Maryland Hospital Clinton  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year   If Under 24 Hrs.   8. Date of Birth										Prince Georges				
( )	Funeral Director		259-40-4680	M 2 1	79	Yrs.	Months	Days	Hours	Min.	8. Date of Bin (Month, Da 04 1	y, Year)		9. Birthi Cou		e or Foreign	
	and w		Usual Residence of Decedent  10a. State 10b. County		10c. City	, Town or Lo	cation								10d. Inside	City Limits	
	Maryl ehc	Į	MD Prince	Coorgo	For	e to ToT to	ahin	~+~~								es 2 No	
	r 28e	by Funeral Director	10e. Street and Number	Georges	FUL	t Wa	10f. Zip		<u>.                                    </u>			10g. Citi	izen of W	hat Cou	ntry?		
	th with	al D	7916 Jaywick	Avenue	2		2	0744	1					US			
	eme eme	ner	11. Marital Status	12. Was Decede Armed Force	ent Ever in U.S	S. 13.				gin? (Spe	cify Yes or No Rican, etc.)	-	14. Race		can Indian,		
36	or It	y Fu	1 ☐ Never Married 2 ☑ Married	1 ☐ Yes 2 If Yes, Give	<b>K</b> ] No		1 ☐ Yes			,			Specify:				
Ö	hours tural		3 Widowed 4 Divorced	Year or Date	os:	100 Dans	dontio Herr	-1 0				105 10		DI	ack		
21215-0036	within 72 hours atter death with the Maryland ane. than "natural", or iteme 23e or 28e-f ehow he Madical Examinat must be inclifted at	Completed	15. Decedent's Ed (Specify only highest gra	de completed)		16a. Dece (Give life.	kind of wo DO NOT u	rk done d	luring most	of workir	ng	160. KI	nd of Bus	iness/in	idustry		
212	y with jene. r thar	E O	Elementary/Secondary (0-12)	College (1-4	or 5+)	Ног	ısewi	ife				Owr	n Hom	ne			
Þ	be filed tal Hygie d other	Bec	17. Father's Name (First, Middle, Last)		,	1.0	150 11 .		18. Mother	r's Name	(First, Middle,						
/lai	ould by Menta arked atic a	ToE	Unknown						Wi1	1ie	Bell	Hen	ry				
Maryland	2 should be and Mental Is marked is aumatic av		19a. Informant's Name/Relationship (7			19b. Mailir	ng Address	(Street a	ind Numbe	r or Rura	Route Number	er, City o	r Town, S	itate, Zip	Code) 2	0744	
	s 1 and 2 should be filed within 72 hours atter death with the Marylan of Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23s or 28s-1 show other traumatic avant. The Medical Examinar must be notified at		Edward I. Har	ris/Hus		7916	Jay	Wic	k Av	enue	e, For	t W	ash:	ing	ton,	MĎ	
Baltimore,	Pages in the hent of hent of hent of hent of hent. If Ite		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐			ace of Dispo emetery, crer	natory or o	nther place	9)	U	ate	20c. Lo	cation - C	city or F	own, State		
틆			4 ☐ Donation 5 ☐ Other (Specify 21. Signature of Funeral Service Licen		Ar1	ingto	n Na	at'1	C11b	03-0	01-06	Arl	ing	ton	, VA		
Ba	permit. Departr Importa		Garage of Full- and Service City	Street	600	. 60	. Name at	Id Addres	s of Facility	Str	icklan	d F	une	ra1	Ser	vices	
**			23a. Part 1. Enter the disease, or comp	olications that cau	sed the death.						oad, C		Sp.	ring	Approxim	nate	
	Physician		shock, or heart failure. List only one cause on each line.														
	/Medical		Immediate Cause (Final disease or condition resulting in death)  a. Atteroscleratic Candio Vasulan Disease  Due to (or as a consequence of):  End Stage Real Disease  34										<del>5</del>				
	Examiner		Sequentially list conditions	b E	not S	fage	1	len	ni	Sea	u				3	4-	
	D #	lner	if any, leading to immediate  Due to (or as a consequence of): cause. Enter Underlying									3			<del>J</del>		
	and -trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	C	as a consequ												
8760,	icate be executed physician and s the burial-transit	alE		Due 10 (01	as a consequ	ierice Oi).											
687	titicate ng phys as the	edical		d										+			
Box	death certitic e attending p id tor use as	Ž.	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcor								2	23d. Date	of delive	erv		
œ.		Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☑ No	4 Pregnan	1 2 ☐ Fetale t at time of de		]Ectopic pr ] Other (sp						Mont	th	Day	Year	
P. 0.	that the de ed by the a detached t	hys	9 Unknown	9∐ Unknow													
s,	igne be d	þ	Part II. Other significant conditions co	ntributing to deat	h but not resul	lting in the u	ndertying c	ause give	n in Part I.		23e. Did to						
ord	w require been si should t	ted									1 U Y	/es 2[	_INo 3	Prot	bably 4 [	Unknown	
3ec	e law has b	Completed							-		24a. Was autop	sy	pr	or to co	psy finding mpletion o	s available cause of	
a	n: Th licate r. pag											ormed? death? 2 No 1 Yes 2 No					
₹	certil	Be c	25. Was case referred to medical examiner?  1 Yes 2 No	Hospital:				Othe	-		(Check only o						
ō	9 Phy er this eral d	٦ 2	27. Manner of Death	28a. Date of I		P/Outpatien 28b. Time of		, A	4 🗆 1901		ne 5 ☐ Resid 8d. Describe h				(y)		
Ö	ttending death. stor: Atte / the tun	atlo	27. Manner of Death 12 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be determined 4 Homicide 28a. Date of Injury 28b. Time of Injury 28b. Time of Injury 4 Work? 1 Yes 2 No 28b. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28b. Time of 28c. Injury at Work? 1 Yes 2 No 28b. Describe how in 28c. Injury at Work? 28b. Describe how in 28c. Injury at Work? 28b. Describe how in 28c. Injury at Work? 28b. Describe how in 28c. Injury at Work? 28b. Describe how in 28c. Injury at Work? 28b. Describe how in 28c. Injury at Work?									and Number or Rural Route Number					
Division of Vital Records,	l or Atte attar de Directo I in by th	Certification;									Street and						
0	itel o rrs att rel DI lled in																
	To the Hospitel or Attending Physicien: The within 24 hours atter death.  To the Funerel Director: Alter this certilicate ha complately tilled in by the tuneral director, page	Medical	29a. Certifier Check only one) 2 Medical Exam	iner: On the basi:	s of examination	vledge, death ion and/or inv	occurred estigation	at the time , in my op	e, date and inion, deatl	d place, a h occurre	nd due to the d d at the time, d	cause(s) date and	and man	ner as s	tated. o the cause	e(s)	
	o the o the omple	Med	29b. Signature and title of certifier	and manner			290	. License	number			29d. Date	Date signed (Month, Day, Year)  2-25-2006  a: MO2745				
	- s + ō		mosula	>M-0				ni	101	65		0	2 - 2	5-	200	6	
)	(E)	-	30. Name and address of person who o	ompleted cause of	of death (Item	23a) (Type,	Print)		-77			, ,					
_	9		Michael Sidar	ens ind	2 11-	70/ h	Ling.	Stone	WA	111/2	H LASI	boto	M	05	07(	4.5	
	Sta	_	31. Date filed (Month, Day, Year)	32. Regi	strar's Signatu	UTB.	80			,							
	Registra	al a	MAR 0 1 2006	Late of the	1 1	ALLEN											

State of Maryland / Department of Health and Mental Hygiene Reg. No. | 6 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** George Fox February 2006 6:17P Hamilton /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 9832 Green Valley Rd. Union Bridge Frederick 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Months, Pay, Year) 916 5. Social Security Number 9. Birthplace (State or Foreign Funeral 1[XM 2□ F Virginia Director 215-20-7681 Usual Residence of Decedent the Maryland 10a State 10c. City. Town or Location 10b County 10d. Inside City Limits r than "natural", or Items 23s or 28s-f show the Medical Examinar must be notified at 1 Yes 2 No Director Frederick Union Bridge Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9832 Green Valley Rd. 21791 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Saltimore, Maryland 21215-0036 Completed by 1 Yes 2 No Specify: Specify: White 3 XWidowed 4 ☐ Divorced 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) security guard air conditioning mfg. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be should be fi Charles Leroy Fox Elvira Frances Kendig 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 Is m any injury or other traum once. E. Louise Fox/ daughter 9832 Green Valley Rd. Union Bridge, MD 21791 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Linganore Cemetery 3/2/2006 4 □ Donation 5 □ Other (Specify) Unionville, MD 22. Name and Address of Facility Hartzler Funeral Home 21. Signature of Paneral Service Licencee atharine 11802 Liberty Rd. Libertytown, MD 21762 23a. Part 1. Enter the disease, or complications that daused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Congestive Heart Failure **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated exercises. Due to (or as a consequence of) Examiner The law requires that the death certificate be executed attending physicien and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Month Day 4☐Pregnant at time of death 5 Other (specify) been signed by the a should be detached to 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š Hypertersion Corony Asky Discuse Dubakes Mellita Chronic Revel 1 ☐ Yes 2.2 No 3 ☐ Probably 4 ☐ Unknown Completed Recover + Preumonta 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ♣ No page 2 autopsy performed? 2 0 No 1 Yes After this certification, funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident Director 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) WJL 1/toll mi DY3780 2/28/06 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2 Kevin E. Hohl MD 300 S. Church St. Bildle town MD 21769 31. Date filed (Month, Day, Year)
MAR 0 32. Registrar's Signature State Elsen & Speak 2006 Registrar

			1 - For State Registrar	State o	f Marylan	•	artment <i>rtificate</i>				lental Hyg R	jiene eg. No.	000	5	07968		
			1. Decedent's Name (First, Middle, Last)  2. Date of Death Month							th Day	Day Year						
	Physici /Medio		Johnnie Louis Hale February														
	Examir		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death								4c. (	4c. County of Death					
			Longview Nursing				Mano			0414			Carro				
	Funeral Director		5. Social Security Number 6. 228-30-6495	last birthday) Yrs.	If Under Months	If Under Hours	8. Date of Birth (Month, Day Feb. 18	Month, Day, Year)			Birthplace (State or Foreign Country) Virginia						
	and *		Usual Residence of Decedent  10a. State 10b. County		10c. Cit	y, Town or Lo	cation							10	0d. Inside City Limits		
	f sho	ō	MD Carrol	.1	W	estmin	ster								1 ∐ Yes 2 📆 💢 o		
	28e	rect	10e. Street and Number				10f. Zip	Code				0g. Citiz	en of Wha	it Coun	try?		
	3a or	Ö	949 Klee Mill Ro	l.			21:	L57				US	SA				
	ms 2	Jers	11. Marital Status	12. Was Dece	edent Ever in U	.S. 13.	Was Decede	ent of His	spanic Ori	gin? (Spe	ecify Yes or No-	1	4. Race -				
21215-0036	within 72 hours after death with the Maryland ene. than "neturel", or items 23a or 28e-f show ha Madical Examirat remail the notified at	Completed by Funeral Director	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Pivorced	Armed Fo 1 Pes If Yes, Giv Year or D	2 □ No ⁄e		1 ☐ Yes 2		Specify:	i, Fuelto	nican, etc.)		Specifys,	White, o	nite		
0-10	72 hor	ted	15. Decedent's 8	Education			dent's Usual kind of work			t of worki	ina	16b. Kin	d of Busin	ess/Ind	dustry		
218	thin 7	hpie	(Specify only highest g. Elementary/Secondary (0-12)	College (1	1-4or 5+)	life.	DO NOT us	retired)	dring mos	Q OF WORK	ng						
	filed withi Hygiene. other than ent, the M	S	12			War	ehouse							У			
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "neturel; or items 23a or 28e-f show any injury or other traumatic event, the Medical Examinat must be notified at once.	To Be	17. Father's Name (First, Middle, Las Jackson Coleman	Hale							o (First, Middle, Ohnson	Maiden S	Sumame)				
Mary		•	19a. Informant's Name/Relationship Gary Hale - So				-					-			Code)		
Baltimore,			20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☐  4 ☐ Donation 5 ☐ Other (Spec		State	Place of Disponentery, created anklin	natory or oti	her place			h 3,200	Do					
Baltir			21. Signature of Funeral Service Lice			22	2. Name and	Addres	s of Facili	y Pri	tts Fun	era1					
			23a. Part1. Enter the disease, or con	nplications that o	aused the deat	h. Do not ent	er the mode	of dying	, such as	cardiac o	or respiratory arr	est,	-		Approximate		
	Physician /Medical Examiner		shock or heart failure. List only one cause on each line.										Onset and Death				
	uted 1 ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b	(or as a conseq	uence of):											
68760,	cate be executed physician and the burial-transit	dicai Exa	resulting in death) Last	Due to	(or as a conseq	uence of):											
9		. w .															
O. Box	The law requires that the death certifi ate has been signed by the attending page 2 should be detached for use as	Completed by Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 Live b	tcome of pregna birth 2 ☐ Feta nant at time of d own	Ideath 3	Ectopic pre Other (spe					2					
P.0	that t ed by detac	H.	Part II. Other significant conditions	contributing to de	eath but not res	ulting in the u	nderlying ca	use give	n in Part I		23e. Did to	bacco us	se contribu	ite to th	e cause of death?		
ds	uires sign ld be	d b	MIDDM	1+-+	10						1 🗆 Y	es 2	]No 3	Prob	ably 4 Unknown		
Ö	w requir been si should	ete									24a. Was a	ın	24b. We	re autor	osy findings available		
A S S S S S S S S S S S S S S S S S S S								med?	death?								
a	ification, per			e Co	25. Was case referred to medical	1					26 Place	a of Death	1 ☐ Yes				
>	/sicie	To B	examiner? 1 ☐ Yes 2 🛣 No	Harasitalia Ohaan I						Home 5 ☐ Residence 6 ☐ Other (Specify)				<i>'</i> )			
10	g Phy er thi		27. Manner of Death						28d. Describe h		23d. Date of delivery Month Day Year  co use contribute to the cause of death?  2 \( \text{No} \) 3 \( \text{Probably} \) 4 \( \text{Munknown} \)  24b. Were autopsy findings available prior to completion of cause of death?  1 \( \text{Yes} \) 2 \( \text{No} \)  6 \( \text{Other} \) (Specify)						
Ö	ath. r: Aff	atio	1 Natural 5 ☐ Pending 2 ☐ Accident investigati	on	,,	,,	М		es 2□	No							
Division of Vital Records,	al or Atter after de I Directo d in by th	Certification;	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	eet, factory, office 28f. Location (St City or Town					treet and n, State)	eet and Number or Rural Route Number, State)							
	To the Hospital or Attending Physicien: The law within 24 hours after death.  To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2	edical C	29a. Certifier (Check only one)  1 Certifying F	Physicien: To the aminer: On the band man	best of my kno asis of examina ner stated.	owledge, deat ation and/or in	h occurred a vestigation,	it the tim	e, date ar inion, dea	nd place, ath occurr	and due to the c red at the time, d	ause(s) a	and mann place, and	er as st I due to	ated. the cause(s)		
	To th Withir To th	Me	29b. Signature and title of certifier				29c. License number 29d. Date signed (Month, Day, 2 - 27 - 0							Day, Year)			
	11-		> afansw	Mycon	nD			D	05	170	5	2	- 2	7.	-06		
	MZ		30. Name and address of person who			n 23a) (Type,		R	He	str	mins?	res	00	D	21157		
	Sta	ite	31. Date filed (Month, Day, Year)	32. R	Registrar's Signa												

	1	For Stata Registrar	Otato of Ivi	ar y tarn	C	ertifica	ite of D	eath	F	Reg. No	_	01707
Physician		Decedent's Name (First, Middle, La	•						2. Date of Dea Month	Day	Year	3. Time of Death
/Medical	١,	Cyla Ia. Facility Name (If not institution, giv	Handelsman			4h Cit	v Town ort	ocation of Deat	February		, 2006 County of Death	10:55P M
Examiner		Shady Grove Ad		spita	a1		ockvil				Montgome	
Funeral Director		146-38-6620	Sex 7. Ag	e (In yrs. I	ast birthda Yrs.	Month		If Under 24 Hrs Hours Min.	8. Date of Birth (Month, Day March 3	Year)	9. Birtt Co Po	nplace (State or Foreign untry) Land
rz nouts aller death with the Maryland Instural, or Iteme 23e or 28e-f show dical Exerciter must be notified at	-	Usual Residence of Decedent  10a. State 10b. County		10c. City	, Town or	Location						10d. Inside City Limits
find and	5	Maryland Montg	omerv		R	ockvi	11e					1 XYes 2 □ No
tor 28a-f s be notified		10e. Street and Number				10f. 2	Zip Code			•	izen of What Co	,
a 23a		6121 Montrose			-		2085					of Americ
rthan "natural", or Itame 23a or 28a-f show the Medical Examinat must be notified at Completed by Funeral Director	2	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Armed Forces? 1  Yes 2  If Yes, Give Year or Dates:		5.		cedent of Hispocecify Cuban,		pecify Yes or No- to Rican, etc.)		14. Race - Ame Black, White Specify:	
t, tre Medical Completed	בובר	15. Decedent's E (Specify only highest gr			(Gi	ve kind of	sual Occupati work done du	on ring most of wo	rking	16b. K	ind of Business/	ndustry
than than	2	Elementary/Secondary (0-12)	College (1-4or 5	5+)			use retired) 1 Insp	ector			Apparel	1
office of the Co	5	17. Father's Name (First, Middle, Las	)			pparc			ne (First, Middle,	Maiden		
To B		Israel Shmuel	Goldberg					Henia	Frumansk	ta		
or trauma		19a. Informant's Name/Relationship Jacob Handelsma							ural Route Numbe ie, North			
Importent: If Itam 27 is marked eny injury or other traumatic once.	2	20a. Method of Disposition 1		ÇE	emetery, c	ah Ce	rotherplace) metery	02/		Far		New Jersey
eny infr		21. Signature of Euneral Service Lice	nsee									Home, Inc ng, MD 2090
sician edical		23a. Part1. Enter the disease, or con shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. Phew	no. Mon	ia	enter the m	ode of dying,	such as cardia	or respiratory an	rest,		Approximate Interval Between Onset and Death
niner			Due to (or as									•
the burial-transit	LYa	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as				<del></del>					
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etached for use	Iyalcıdı	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	1 Live birth 4 Pregnant at	2 Fetal	death :	3 Ectopic 5 Other	pregnancy (specify)				23d. Date of deli Month	very Day Year
e e	֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓	Part II. Other significant conditions	contributing to death b	ut not resu	ulting in the	underfying	g cause given	in Part I.		bacco u		the cause of death?
page 2 should be completed	and line								24a. Was a autop perfor	sy	prior to death?	topsy findings available completion of cause of
certificate rector, pag	U	25. Was case referred to medical examiner?							ath (Check only or	7e)		
E E		1 ☐ Yes 💆 No 27. Manner of Death	Hospital: 15 Inpatie		ER/Outpat		DOA Other:	4 Nursing F	lome 5 Resid			nfy)
e funer		Natural 5 Pending 2 Accident Investigation	(Month, Da	y Year)	28b. Time Injur		28c. Injury a Work? 1 \( \text{Ye}	ıt es 2 □No	28d. Describe h	ow injui	ry occurred	
ed in by the funera		3 Suicide 6 Could not to determined	28e. Place of Inj building, et	ury - At ho c. (Specify	me, tarm,	street, fact	ory, office		28f. Location (S City or Tow	treet an n, State	d Number or Ru a)	ral Route Number,
No the Funeral Directompletely filled in by		29a. Certifier (Check only one) Certifying P	nysician: To the best miner: On the basis o and manner st	t examinat	wledge, de tion and/or	ath occurre investigati	ed at the time on, in my opir	, date and place nion, death occu	e, and due to the curred at the time, c	ause(s)	and manner as d place, and due	stated. to the cause(s)
compl		29b. Signature and title of certifier	4 1				9c. License r				te signed (Monti	
			J. Mist	1	MO		DSG	1738		eb	ruary	24,2006
		30. Name and address of person who Alicia T. M		leath (Item	23a) (Typ	elica	1 Can	ver pr	ive Ru	(KU	ille, Mi	24,2006
State	•	31. Date filed (Month, Day, Year)	32 Registr	ar's Signa	ture	ande)	,					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Year **Physician** 5:17 A M KATHY JOHNSON March 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner University of Manyland Medical Center Baltimore Baltimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year, 10-15-1957 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 F 261-31-1862 48 Texas Director Usual Residence of Decedent death with the Manyland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits **ehow** Pages 1 and 2 should be filled within 72 hours after death with the Marylar nent of Heath and Mantal Hygens. It is floor 27 is marked other than "nature!; or itema 23a or 28a-1 ehow mury or other treumatic event, Ita Madical Exactination froiting at 1 TYAS 2 NO **Funeral Director** MD St. Mary's Lexington Park 10f Zin Code 10g Citizen of What Country? 10e Street and Number 48464 Mattapony Road 20653 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify. Completed by 3 ☐ Widowed 4 ☐ Divorced White 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Electronic Technician Government Contractor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Jerry Merriman Nellis Robb ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robin Johnson/Husband 48464 Mattapony Road, Lexington Park, ND 20653 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town. State permit. Pages Department of Important: if it eny injury or o 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Brinsfield-Echols 3-9-2006 Charlotte Hall, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Mineral Sengton Defisee

Edward N. Brinsfield, Jr. 22. Name and Address of Facility Brinsfield Funeral Home, P.A. 22955 Hollywood Road, Leonardtown, MD 20650 M00052 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Graft versus Host **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) P.O. Box 68760. Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy in the past 12 months? Month Dav Year 4☐Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, enons No 3 Probably 4 Unknown 1 Yes 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? page this certificate Division of Vital Yes 2 No 1 TYes Hospitel or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Other 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient ٩ 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manger of Death 28b. Time of 28d. Describe how injury occurred Certification: After Injury 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No M investigation 2 Accident the within 24 hours after deatl To the Funerel Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by 4 Homicide 1 crtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) ۽ 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 19657 MD 225 Greene St. Baltimore, MD 21201 YOUNO, egistrar's Signature State Registrar

			For State Registrar	State of Maryland / Depa	artment of He <i>rtificate of D</i>		al Hygien	0	07971
Ţ.	Physician	ė	1. Decedent's Name (First, Middle, Las	0			ate of Death	ay Year	3. Time of Death
·	Physici /Medic Examir	al	Eldrige 4a. Facility Name (If not institution, give	Johnson street and number)	4b. City, Town, or L	Feb	ruary	22,2006 lc. County of Dea	
	Funeral Director		3/3-44-304/		Clintor If Under 1 Year Months Days		ate of Birth fonth, Day, Yea Drill23	1914 9. Bir	Georges thplace (State or Foreign buntry) tryland
	and w		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or Lo	ocation				10d. Inside City Limits
	Maryl -f ehc	ğ	MD Prince	Georges Brandy	vine				1 XYes 2 ☐ No
	th with the 23s or 28s	ai Direc	10e. Street and Number 13507 Tower Ro	1.	10f. Zip Code 2 0	0613	10g. C	Citizen of What Co	ountry?
900	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other then "natural", or items 23s or 28s-f show any injury or other treumatic event, the Medical Examinar must be coalified at ODEs.	d by Funeral Director	11. Marital Status  1 XNever Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 □Yes 2 ® No	If Yes, specify Cuban,	panic Origin? (Specify Y Mexican, Puerto Rican <i>Specify:</i>	es or No- , etc.)	14. Race - Ame Black, Whit Specify: B	
Maryland 21215-0036	within 72 h ene. then "natu	Completed	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12)	de completed) (Give life.	dent's Usual Occupati kind of work done du DO NOT use retired)	ring most of working	Pri	Kind of Business ince Ge ard of	•
<u>0</u>	filled Hygin other	Be Co	17. Father's Name (First, Middle, Last)	Bul	lding En	1910er 18. Mother's Name <i>(Firs.</i>		-	
lan	uld be Aenta rked tlc ev	To B	Willie Johnso	on		Henriet	ta Smi	ith	
ary	2 should have have		19a. Informant's Name/Relationship (T			d Number or Rural Rou			
	and 2 ealth m 27			Johnson/niece 135					
altimore,	Pages 1 tment of H tant: If Ite		20a. Method of Disposition  1   ↑ Burial 2 □ Cremation 3 □ 1  4 □ Donation 5 □ Other (Specify,	Resurr	matory or other place) ection	3/6/0	6 Cli	Location - City or	Md.
Ba	permit Depar Impor any in		21. Signature of Fureral Sorvice Licens	See Z	2. Name and Address Adams Fun	of Facility Leral Home	PA-2	20605 A	quasco Rd
Ė			23a. Part1. Enter the disease, or comp shock, or head failure. List only of	lications that caused the death. Do not en	ter the mode of dying,	such as cardiac or resp		aquasco	MD 20608 Approximate Interval Between
10	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	. /	LDIAL IN	IFARC TION	)		Onset and Death
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P.O. Box 6	death certif e attending id for use as	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown		Ectopic pregnancy Other (specify)			23d. Date of de Month	livery Day Year
	Physicien: The law requires that the this certificate has been signed by the rail director, page 2 should be detache		Part II. Other significant conditions co	ontributing to death but not resulting in the u	inderlying cause given	in Part I. 2			o the cause of death?
Division of Vital Records,	The law requir ate has been si page 2 should t	Completed					4a. Was an autopsy performed?  ☐ Yes 2 1	prior to death?	utopsy findings available completion of cause of
Ita	ysicien: The lis certificate hadirector, page	Bec	25. Was case referred to medical examiner?			26. Place of Death (Che			
5	Physic this candire	2	1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpatient 2 ☑ ER/Outpatien		4   Nuising Home 5			cify)
sion (	Jing After fune	Certification:	27. Manner of Death  1	28a. Date of Injury (Month, Day Year) 28b. Time of Injury	M 1 ☐ Ye	s 2 No	escribe how in		
$\frac{1}{2}$	el or At s after c	Sertifi	4 Homicide determined	28e. Place of Injury - At home, farm, st. building, etc. (Specity)	reet, factory, office		ity or Town, Sta		ural Route Number,
	To the Hospitel or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical (	29a. Certifier (Check only one) 1 ☐ Certifying Phy 2 ☐ Medical Exam	vsician: To the best of my knowledge, deat iner: On the basis of examination and/or in and manner stated.	h occurred at the time estigation, in my opin	, date and place, and du nion, death occurred at t	ue to the cause( the time, date a	(s) and manner as nd place, and due	s stated. e to the cause(s)
)	To the within to the comp	×	29b. Signature and title of certifier		29c. License n			ate signed (Mont	th, Dey, Year) 26, 2006
/	B		30. Name and address of person who con TERRY JOD RIE	ompleted cause of death (Item 23a) (Type, , MD 7503 SURR	ATTS ROA	B, CLINTOI	U, MARCI	CAND!	20735
	Sta Registr		31. Date filed (Month, Day, Year)  MAR 0 2 2	32. Begistrar's Signature	parti				
Dh	MH 17 Rev 1/2	001		-					

DHMH 17 Rev 1/2001

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	State of Mary		artment of Heal rtificate of Dea		ıtal Hygier Reg. I	2006	07972
	Physici /Medic		Decedent's Name (First, Middle, La John James	st) John:	ston			Date of Death Month Iarch 9	Day 2006 Year	3. Time of Death 7:50 P <sub>M</sub>
	Examin			ursing Home		4b. City, Town, or Loca Westernpo	ort		4c. County of Death Allegany	
	Funeral Director		5. Social Security Number 232–26–2608  Usual Residence of Decedent	Sex MCXM 2□F 84	yrs. last birthday)  Yrs.		ours Min. A	Date of Birth Month, Day, Yes ug. 7,	ar) 1921 West	place (State or Foreign htry) Virginia
	Maryland	tor	10a. State WV. 10b. County Mineral	106	City, Town or Lo					10d. Inside City Limits 1X Yes 2 ☐ No
	th with the 23a or 28s	Funeral Director	10e. Street and Number 84 West Harrison	n St.		10f. Zip Code 26750		_	Citizen of What Cou ited State	•
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Exerciting restricting at Once.	þ	11. Marital Status  1 □ Never Married 2 □ Married  **StWidowed 4 □ Divorced	12. Was Decedent Ever Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates:	WWZ	Was Decedent of Hispani If Yes, specify Cuban, Me 1 ☐ Yes 2 ☑ No Spe		Yes or No- an, etc.)	14. Race - Ameri Black, White, Specify: Wh	etc.
21215-0036	within 72 ho iene. rthan "natur ine Medical	Completed	15. Decedent's E (Specify only highest gr. Elementary/Secondary (0-12)	ducation ade completed) College (1-4or 5+)	(Give	dent's Usual Occupation kind of work done during DO NOT use retired) aper Maker	g most of working		. Kind of Business/Ir aper Manu:	
Maryland 2	nutd be filed Mental Hyg arked other atic event,	To Be C	17. Father's Name (First, Middle, Last John James	Johnston		18. 1	Mother's Name <i>(Fi</i> Myrtle	rst, Middle, Maid Pence		
	and 2 sho ealth and I n 27 Is me		19a. Informant's Name/Relationship (Carolyn Johnston	/ daughter	84 W	ng Address (Street and N est Harrisor	n St., Pi	.edmont,	WV. 2675	) 
Baltimore,	Pages 1 Iment of Hu tant: If iter jury or oth		20a. Method of Disposition  1   Burial 2 □ Cremation 3 □  4 □ Donation 5 □ Other (Speci	(y)	Philos Co		03/13/ 2006	We		own, State , Maryland
Bal	Departiment Departiment Important Im		21. Signature of Funeral Service Lice	e Sorl	1	2. Name and Address of B	St., West	ernport		1 21562
30,	Livate be executed / Medical Examiner   Physician and   Physic	il Examiner	23a. Part1. Enter the disease, or conshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Undeate or must that initiated events resulting in death) Last	A	nsequence of):	Qementi A	un 23 curdina 3 1 0	spiratory arross,		Interval Between Onset and Death
P.O. Box 68760,	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of p 1 Live birth 2 4 Pregnant at time 9 Unknown	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of deliv Month	ery Day Year
	w requires that been signed by should be deta	Completed by Pr	Part II. Other significant conditions  Own my ha	try hisense	_					he cause of death?  bably 4 Staknown  posy findings available
al Rec	n: The lav ficate has nr, page 2		ty per fen s  25. Was case referred to medical					autopsy performed 1 ☐ Yes 2 🔀	prior to co death?	empletion of cause of
Division of Vital Records,	To the Hospital or Attending Physicien: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	ation; To Be	examiner?  1 Yes 2 Yo  27. Manger of Death	28a. Date of Injury (Month, Day Ye	2 ER/Outpatier  28b. Time of Injury	nt 3□ DOA Other: 4,	28d.		e 6 □Other (Speci njury occurred	fy)
Divis	tal or Atters after detail Directo	Certification:	3 ☐ Suicide 6 ☐ Could not to determined		At home, farm, st Specify)	reet, factory, office	28f.	Location (Street City or Town, St	t and Number or Aur late)	al Route Number,
	the Hospi nin 24 hou the Funer	Medical	(Check only 2 Medical Exa	hysician: To the best of m miner: On the basis of exa and manner stated.	mination and/or in	vestigation, in my opinion	n, death occurred a	it the time, date	and place, and due t	o the cause(s)
)		A	29b. Signature and title of certifier			29c. License num	44	3	Date signed (Month, $3/10/20$	
le	AVA		Dr. Jesus Tan,	completed cause of death Broadway St	(Item 23a) (Type, Frost	burg, Maryl	and 2153	2		
	Sta Regist		31. Date filed (Month, Day, Year) MAR 1 0	32. Registrar's	Signature	hant .				

			For State State Registrar	e of Maryland /		artment of He <i>tificate of D</i>			ene	6	0 / 9	73
	74		Decedent's Name (First, Middle, Last)					2. Date of Death Month		V	3. Time of	f Death
	Physici: /Medic		Sara A. Jone	S				March	Day 1 20	Year 006	5:40	A M
	Examin		4a. Facility Name (If not institution, give street an	d number)		4b. City, Town, or	Location of Death		4c. County of	of Death		
			Beverly Health Care	Center		Frede	erick		Fı	eder	ick	
П	Funeral		Social Security Number 6. Sex	7. Age (In yrs. last b	irthday)	If Under 1 Year Months Days		8. Date of Birth			ace (State o	or Foreign
	Director		578-52-4582 1□ M 2⊠	93	Yrs.	Months Days	Hours Will.	(Month, Day, Y Aug. 20,	1912	Mary	land	
	P .		Usual Residence of Decedent									
	aryla show	_	10a. State 10b. County	10c. City, To						11	Od. Inside Ci	
	Ba-f	cto	Maryland Washington	На	gers	town					1 Y <i>e</i> s	2 ⊠ No
	ith th	Directo	10e. Street and Number			10f. Zip Code		100	g. Citizen of W	hat Coun	try?	
	death with the Maryland ims 23a or 28a-f ehow imst be notified at	a	735 Marathon Drive			217	740		Unite	ed St	ates	
	sep .	Funeral	11. Marital Status 12. Was	Decedent Ever in U.S. ed Forces?	13. V	Vas Decedent of His Yes, specify Cubar	spanic Origin? (Sp , Mexican, Puerto	ecify Yes or No- Rican, etc.)		- Americ	an Indian,	
2	or it	ΥF	If Ya	res 2⊠ No s, Give		I□Yes 2☑No	Specify:		Specify:		ite	
3	72 hours after natural', or ite	d by		or Dates:								
<u>n</u>	n 72 hours after death with the Marylan "natural", or Items 23a or 28a-f show solical Examiner must be notified at	Completed	15. Decedent's Education (Specify only highest grade comple	nted)	a. Deced (Give	lent's Usual Occupa kind of work done do OO NOT use retired)	tion u <i>ri</i> ng most of work	ing 16	6b. Kind of Bu	siness/Inc	lustry	
٧	vithir ne. hen	d L	Elementary/Secondary (0-12) Colle	ge (1-4or 5+) 12					Orm	Home		
7	lled v tygie ther t		17. Father's Name (First, Middle, Last)	12	п	omemaker	10. Moth ada Nom.	o (Cino Adiatalo Ado				
<u>a</u>	be f ntal h od of	Be						e (First, Middle, Ma		•		
Š	should be filed within 72 hours nd Mental Hygiene. o marked other then "natural", umatic event, the Medical Exe	To	Unknown Vermi				Unkno			Jnkno		
	12 st h and 7 ie n traun		19a. Informant's Name/Relationship (Type, Print)			g Address (Street a						
, L	1 and 2 Heelth In 27 i		Raymond McGarvey / So 20a. Method of Disposition			Taveshire		Bethesda,	Mary La			
5	ges If of F		1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal 1	rom State cemet	ery, cren	natory or other place	Mar		c. Location - (	Jity or 10	wn, State	
allillo	tant:		4 Donation 5 Other (Specify)	Frede		Cremator	у 3,	2006 F	rederio			
ğ	permit. Peges 1 and 2 should be filed within Department of Heelih and Mental Hygiene. Important: If item 27 ie marked other then eny injury or other traumatic event, Item 000s.		21. Signature of Funeral Service Licensee	-1		. Name and Address	DLa	uffer Fu				
_	₫ O E e ol		- Elite		_	21 Opossu			rick,	Mary.	Land 2	21702
			23a. Part1. Enter the disease, or complications t shock, or heart failure. List only one cause	hat caused the death. Do on each line.	not ente	er the mode of dying	, such as cardiac	or respiratory arres	t,		Approximat Interval Bet	ween
Ę.	Physician		Immediate Cause (Final disease or condition	andiami	DO	thu					Onset and i	Death
	/Medical		resulting in death)	e to (or as a consequence	0):	1						
	Examiner		Sequentially list conditions b									
7	D =	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	e to (or as a consequence	ol):							
	ocute nd trans	аш	that initiated events									
Š	e exe	Ä	resulting in death) Last Du	e to (or as a consequence	ol):							
0/0	icate be executed physicien and s the burial-transit	edicai	d	· · · · · · · · · · · · · · · · · · ·								
		Wed	IF FEMALE:									
Š	th ce tendi	an/I	23b. Was decedent pregnant 23c. If yes	s, outcome of pregnancy ive birth 2 ☐ Fetal dear	h 3□	Ectopic pregnancy			23d. Date		-	
	a dea	SC	1 Yes 2 No	regnant at time of death Joknown		Other (specify)			Mon	th	Day 1	Year
ׅׅ֡֝֝֡֝֝֡֝֡֡֝֜֝֡֝֡֝֡֡֡֝֡֡֝֡֡֡֡֡֡֡֡֡֡֝֡֡֡֡֡֝֡֡֡֡֡֡֡֡	w requires thet the death certif been signed by the attending should be detached for use a	Physician/M	9 🗆 Unknown		-							
, S	gned be de	þ	Part II. Other significant conditions contributing	to death but not resulting	in the ur	derlying cause give	n in Part I.	23e. Did toba	cco use contri	bute to th	e cause of d	leath?
2	en si ould		- CANOMIC UISS	TUCHVE	1	urmay	ary	1 ☐ Yes	2 □ No	3 Proba	ably 4 ⊡(	Ínknown
3	aw r as be 2 sh	Completed				ais	sedie	24a. Was an	24b. W	ere autop	sy lindings	available
Ē	The hard	E	- Anemia					autopsy performe	ed? de	ath? □ Y <i>e</i> s		ause or
<u> </u>	en: rtifica tor, p	0	25. Was case referred to medical				26. Place of Deat	(Check only one)	2140		20 140	
>	ysici is cer direc	To B	examiner? 1 Yes 2 No Hospital:	1 ☐ Inpatient 2 ☐ ER/C	utpatien	Otho	-	me 5 ☐ Residenc	ce 6 ∏Othe	r (Specify	·}	-
5	g Ph er th er al		27. Manner of Death 28a. D	Date of Injury Month, Day Year) 28b.	Time of	28c. Injury Work		28d. Describe how			,	
<u> </u>	ndin ath. r: Aft	ate	1 Natural 5 □ Pending 2 □ Accident investigation	Wichin, Day 16ai)	Injury		es 2 □No					
2	Atte	€	3 ☐ Suicide 6 ☐ Could not be 28e. 6 ☐ Could not be 28e. 6	Place of Injury - At home,	arm, stre	eet, factory, office		28l. Location (Stre		r or Rura	Route Num	nber.
5	s effe	Certification:		ouilding, etc. (Specify)				City or Town,	J(4(8)			
	hour hour mere y fille	1	29a. Certifier Certifying Physician: T	o the best of my knowled	je, death	occurred at the time	e, date and place,	and due to the cau	se(s) and man	ner as st	ated.	
	To the Hospital or Attending Physician: The law requires thet the death certif within 24 hours elter death. within 24 hours elter death. To the Funeral Director: Afler this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use a	Medical	(Check only 2 Medical Examiner: On t	he basis of examination a manner stated.	nd/or inv	estigation, in my opi	nion, death occurr	ed at the time, date	e and place, a	nd due to	the cause(s	i)
	To the To the Comp	ž	29b. Signature and title of certifier			29c. License	number	29d	I. Date signed	(Month, L	Dey, Year)	
						DANG	0417	5	11106			
	2		30. Name and address of person who completed	cause of death (Item 23a	(Туре,	Print)						
			Hemen Shah MD	.650	Ther	mas To	lmson	Dr F	rede	rick	MI	>
8	Sta	te	31. Date filed (Month, Day Year)	32. Regurar's Signature	Le	1 "					- 2	1106

			1 - For Stete Registrer	State of	Marylar		artmen rtificat			and M	ental Hy	giene Reg. Ne	A DA	07974
	Physici /Medic		Decedent's Name (First, Middle, Last  IKE	it)	JOHN	ISON		JR.			2. Date of De Month FEBRUA	Day		- 14
	Examir		4a. Facility Name (If not institution, give 5506 TILDEN ROAD	street and nun	nber)				Location o				County of Dea	ath
	Funeral Director		5. Social Security Number 6. S 148-52-8861	ex M 2□F	7. Age ( <i>In yr</i> s. 47	last birthday) Yrs.	If Under Months		If Under 2 Hours	24 Hrs Min.	8. Date of Bir (Month, Da )ECEMBE	th y, Year)	9. Bi	irthplace (State or Foreign Country) EW JERSEY
	h the Maryland rr 28a-f ehow	Irector	Usuat Residence of Decedent  10a. State 10b. County  MD PRINCE 0  10e. Street and Number	EORGE'S		ity, Town or Lo		Code				10g. Cit	izen of What C	10d. Inside City Limits 1 Yes 2 □ No Country?
36	s 1 and 2 should be filed within 72 hours after deeth with the Maryland if Heelth and Mental Hygiene. If Heelth and Mental Hygiene. Other traumatic event, Ita Mazical Examinational be notified at	by Funeral Director	5506 TILDEN ROAD  11. Marital Status  1 □ Never Married 2阪 Married  3 □ Widowed 4 □ Divorced	12. Was Dece Armed For 1 ☐ Yes If Yes, Giv Year or Da	ces? 2 <b>[X</b> ] No e				spanic Orig n, Mexican Specify:	jin? (Spe , Puerto l	cify Yes or No Rican, etc.)		J.S.A.  14. Race - Am Black, Wh	
21215-0036	d within 72 hou giene. or then "nature" ir madical E	Completed I	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0·12) 10th	ucation		16a. Dece (Give life. SHEET	kind of wo DO NOT u	rk done d se retired	luring most )		ng		ind of Busines:	s/Industry
2	2 should be filed and Mental Hygi Is marked other aumatic event, II	To Be C	17. Father's Name (First, Middle, Last)  IKE JOHNSON	SR.							(First, Middle, MORRIS	Maiden	Sumame)	
	is 1 and 2 sho of Heelth and Item 27 is my other traumy		19a. Informant's Name/Relationship (1 STELLA F. JOHNS 20a. Method of Disposition		206.	5506 Place of Dispo	TILDE	EN RI	BLA	ADENS	BURG,	MARY	TOWN, State, LAND  cation - City o	20710
Baltimore,	Page nent o ant: # ury or		1			cemetery, createry, LN C	EMET:		3/4/		BREI	NTWOOD,	MARYLAND AL HOME	
B	permit. Departr Importe eny Inji		23a. Part1. Enter the disease, or compshock, or heart failure. List only	olications that ca	sused the dea	7	474 L	ANDO	VER R	ROAD	LANDOV	ER,	MARYLAI	
	Physician /Medical Examiner	ner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	a	or as a consec	quence of):	: <	લ્ય	C @	<i>r</i>				Onset and Death  Ay Cars
68760,	The law requires that the death certificate be executed to has been signed by the attending physicien and bage 2 should be detached for use as the burial transit	Physician/Medical Examiner	Cause (Disease or injury that initiated events resulting in death) Last	cDue to (	or as a consec	quence of):								
P.O. Box	that the death certifica led by the attending ph detached for use as the	hysician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown		rth 2 ☐ Feta ant at time of o	af death 3	Ectopic pr Other (sp						23d. Date of de Month	elivery Day Year
rds, F	w requires that been signed I should be det	þ	Part II. Other significant conditions o	ontributing to de	ath but not res	sulting in the u	nderlying c	ause give	n in Part I.		23e. Did t			to the cause of death?  Probably 4 □Unknown
		e Completed	25. Was case referred to medical						26 Place	of Death	24a. Was autor perfo 1 Yes	rmed? 2X No	prior to death?	
ō	ulng Phys	ation: To B	examiner?  1 Yes 2 No  27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of (Mont		ER/Outpatier 28b. Time o Injury	-	8c. Injury Work	or. 4 🗆 Nur	rsing Hon	-1	dence	6 □Other (Sp y occurred	ecify)
Division	<b>9</b> # <b>2</b> €	Certification:	3 Suicide 6 Could not be determined	289. Place buildir	ig, etc. (Speci						City or To	vn, State	)	Rural Route Number,
	To the Hospital within 24 hours of the Funeral completely filled	Medical	29a. Certifier (Check only one) Certifying Ph	ysicien: To the hiner: On the ba and mann	isis of examina	owledge, deat ation and/or in	vestigation	in my op	pinion, deat	d place, a	and due to the ed at the time,	date and	d place, and du	ue to the cause(s)
ŧ	S T T T		29b. Signature and title of certifier	1 Vm	Kh	N		License		32	_	29d. Dai	te signed (Mor	Tof
2	(12)		30. Name and address of person who or DAVID & VAC	1 Ecb	land	m 23a) (Type,	Print)	out	4 16	and	over s	-6,	Balbu	105 max, Nd
77	Sta Registr		MAR 9 1 2006	See	e &	ature	K)							

			1 - For State Registrar	State of Marylan	d / Depa	artment o		d Mental Hy	-	6	07975
		77	Decedent's Name (First, Middle, Last)					2. Date of De			3. Time of Death
8	Physici		JOHNNIE EAR	L JONES	, Sr			Month 0 2	23	Year 06	0145 a <sup>M</sup>
	/Medic Examin		4a. Facility Name (If not institution, give s			4b. City, Tow	n, or Location of D		4c. County		0110 4
	LAGITIII	٠.	Prince Georges				rerly		Princ		eorge
15	Funeral Director	10.0	5. Social Security Number 6. Sex 261 24 9236		ast birthday) Yrs.	If Under 1 You Months Da		8. Date of Bin Min. 03 I	h		place (State or Foreign ntry) rida
	land land		Usual Residence of Decedent  10a. State 10b. County	10c. City	, Town or Lo	ocation				-	0d. Inside City Limits
	permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryland Deperment of Heelth and Mental Hygiene. Important: If item 27 is marked other then "natural", or iteme 23a or 28a-f ehow supprigning or other traumatic event, the Madical Examinar must be notified at ance.	tor	Md Prince G	George For	rt. Wa	shingt	on				1 ☐ Yes 2 🕅 No
	or 284	ired	10e. Street and Number	- 0		10f. Zip Cod			10g. Citizen of V	What Cou	ntry?
	23a	Funeral Director	111 El Camino	Way		207	44		U.S.	Α.	
	teme frame	nue		<ol><li>Was Decedent Ever in U. Armed Forces?</li></ol>	S. 13.	Was Decedent If Yes, specify (	of Hispanic Origin Cuban, Mexican, P	? (Specify Yes or No uerto Rican, etc.)	- 14. Rac Blac	e - Ameni k, White,	can Indian, etc.
36	s afte	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☑ Divorced	1 ☐ Yes 2√☐ No If Yes, Give		1 ☐ Yes 2 🟋	No Specify:			· B1	
21215-0036	tural	edt	15. Decedent's Educ	Year or Dates:	16a Dece	dent's Usual Oc	ccupation		16b. Kind of Bu		
715	n n	Completed	(Specify only highest grade Elementary/Secondary (0-12)	completed)	(Give	kind of work do DO NOT use re	one during most of stired)	working	TOD. THING OF DE	23110334111	dustry
212	d with	mo:	Elementary/Secondary (0-12)	College (1-4or 5+) 4 yrs	Rese	arch A	ssociat	e	Federa	1 G	overnment
ng	be filed tal Hygie d other event, II	Be (	17. Father's Name (First, Middle, Last)				18. Mother's	Name (First, Middle,	Maiden Sumam	10)	
<u>X</u>	should bind Ment ind Ment imarked	To	Lincoln Jones				Nanc	y Turner	c		
Maryland	2 sh and is m		19a. Informant's Name/Relationship (Typ		19b. Maili	ng Address (Str	reet and Number o	r Rural Route Numberd Road	er, City or Town,	State, Zip	Code)
	t and teelth om 27 ther tr		Errika Hameed, d	laugther			yland-2				
Baltimore,	Peges nent of thant: If its ant: If its		1 ☑ Burial 2 ☐ Cremation 3 ☐ Re	emoval from State	emetery, cre	matory or other	place)	Date	20c. Location -	City or 10	own, State
Ë	rtmer rtant njury		4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Theral Services License		. Lin	coln (	Cem 3	/3/06	Brentw	ood,	Maryland
Ba	permit. Depertrimports eny inju		> Buth Cof	fact	6	21 F1c	orida A	venue, N	W, Wasi		RAL HOME ton DC
	Physician /Medical		23a. Part1. Enter the disease, or complic shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	e cause on each line.	una			diac or respiratory air		2	Approximate Interval Between Onset and Death
,092	icate be executed by siclen and buriat-transit	cai Examiner	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence to (or as a consequence)		JRE	enal	fai (	lure		
89		edi	IF FEMALE:								
.O. Box	The law requires thet the death certificat ste has been signed by the attending phy page 2 should be detached for use as th	Physician/M	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9 Unknown	3c. If yes, outcome of pregna 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of do 9 □ Unknown	death 3	Ectopic pregna Other (specify			23d. Dat Mo	e of delive	ery Day Year
Q.	juires thet the de n signed by the a lid be detached f	by	Part II. Other significant conditions con	tributing to death but not resu	ulting in the u	nderlying cause	given in Part I.				ne cause of death?
00	s been si should!	oiete						24a. Was	an 24b. \	Were auto	psy findings available
E E	sicien: The law s certificate has t irector, page 2 s	Completed							rmed?	prior to co death?	mpletion of cause of
/ita	ertific actor,	Be	25. Was case referred to medical examiner?					Death Check only o	ne)		
of	iding Physicien; th, After this certifice funeral director, p	T0	1 195 20 100		ER/Outpatier	" 3D DOX		ng Home 5 Resid			y)
no	Jing I	lon	27. Manner of Death t Natural 5 Pending	28a. Date of Injury (Month, Day Year)	28b. Time o Injury		Injury at Work?	28d. Describe f	now injury occurr	ed	
Division of Vital Records,	f or Attending Physicien: efter death. Director: After this certifica i in by the funeral director, i	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At he building, etc. (Specify	ome, farm, str		1 Yes 2 No	28f. Location (S City or Tov	Street and Numb	er or Rura	l Route Number,
Ω	lospital of hours of uneral D										
	T 4 T 0	edicai	one)	icien: To the best of my kno ler: On the basis of examinal and manner stated.	wledge, deat tion and/or in	h occurred at the vestigation, in n	ne time, date and p my opinion, death o	ace, and due to the occurred at the time,	cause(s) and ma date and place, a	nner as s and due to	tated. the cause(s)
	To the within 2 To the complet	Σ	29b. Signature and title of certifier		-	29c. Lic	cense number		29d. Date signed	d (Month,	Day, Year)
7	P		14565e 3	Imu	e, M	DODO	106036	2	2-2	5-	06
-	(5)		30. Name and address of person who con	mpleted cause of death (Item	23а) (Туре,	Print) A	bese	5. Im	iru		
			31. Date filed (Month, Day, Year)	n SC Fry L	Tura	757	owie	1-(1)	2072	20	
13 kg	Sta Registr		MAR 0 1 2006	Bleeder &	Specie	E)					

		•	For State of Registrar Amend Item #19a Pe	магуland / Depa <b>r FH G854 <sup>Q</sup>9</b>				2.006	07976
	Dhysiair		1. Decedent's Name (First, Middle, Last)				2. Date of Death Month	Day Year	3. Time of Death
4	Physicia /Medic	al .	Barbara J. Jones				February	23 2006	
	Examin	er	4a. Facility Name (If not institution, give street and numb	per)	4b. City, Town, or Lo			4c. County of Death	
			Lorien of Mt. Airy  5. Social Security Number 6. Sex 7	. Age (In yrs. last birthday)	Mt. Ai		8. Date of Birth	Carro	
	Funeral Director		482-20-4095 1□M 282 F	80 Yrs.		Hours Min.	(Month, Day, Y Sept 17	1925 Co	nplace (State or Foreign untry) Iowa
	land	-	Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or Lo	ocation				10d. Inside City Limits
	Mary -f she	ţ	MD Carroll	Mt.	Airy				1 Yes 2 No
	r 28a	Director	10e. Street and Number		101. Zip Code		100	. Citizen of What Co	untry?
	h with	alD	713 Midway Avenue		217	71		USA	
	ams	iner	11. Marital Status 12. Was Deced Armed Ford	ent Ever in U.S. 13.	Was Decedent of Hisp If Yes, specify Cuban,	anic Origin? (Spec Mexican, Puerto P	cify Yes or No- lican, etc.)	14. Race - Ame Black, White	
Maryland 21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. It Health and Sao or 28e-f show itiam 27 is marked other than "natural", or Itams 23e or 28e-f show other traumatic event, Ita Modical Examiner must be notified at	by Funeral	1 Never Married 2 Married 1 Yes, 2 If Yes, Give Year or Dat		1 ☐ Yes 2 ☑ No	Specify:		Specify: [V	White
2	72 hc	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give	dent's Usual Occupation kind of work done dur	on ring most of workin		b, Kind of Business/	Industry
2	within ne. han *	mpl	Elementary/Secondary (0-12) College (1-	4or 5+)	DO NOT use retired)	Coordinat	-or	Formore Tr	an Kanao
22	filed v Hygie ther t		12 17. Father's Name (First, Middle, Last)	POLIC	y Service	8. Mother's Name		Farmers Ir iden Sumame)	isurance
au	d be antal kad o	To Be	Clarence L. Norton			Wilma F.	. Vanzan	t	
ary	2 should be filed within and Mental Hygiene. Is markad other than aumatic avant, ILE M.	-	19a. Informant's Name/Belationship (Type, Print)	19b. Maili	ing Address (Street and	d Number or Rural	Route Number, (	City or Town, State, 2	Zip Code)
	l and 2 lealth a im 27 ls		Janet Sheely/daughter	4215	Hillcrest	Avenue	Hampste	ad, MD 21	L074
ore,	of Hea of Hea fitam rotha		20a. Method of Disposition 1 □ Squrial 2 □ Cremation 3 □ Removal from S	20b. Place of Dispo cemetery, cre	osition (Name of matory or other place)	03/02	72006 <sup>20</sup>	c. Location - City or	Town, State
<u><u>Ĕ</u></u>	Pages ment of I ant: If it ury or o		'4 □Donation 5 □ Other (Specify)	Fairhave	n Memorial				. California
Baltimore,	permit. Pages 1 Department of H Important: If ital any injury or oth		21. Signature of Fureral Service Licensee	2	<sup>2. Name and Address</sup> Pritts Fund 412 Washind	of Facility eral Home	e and Cha	apel, P.A.	21157
			23a. Part1. Enter the disease, or complications that ca shock, or heaft failure. List only one cause on ea	used the death. Do not en	ter the mode of dying,	such as cardiac or	r respiratory arres	LIBUCLY PA	Approximate Interval Between
	Physician			e Respirator					Onset and Death  WK
	/Medical		resulting in death)  Due to (co	r as a consequence of):					_
	Examiner		Sequentially list conditions.	e non-Q wave	myocardia	l infarct	tion		wk
	be fis	Examiner	if any, leading to immediate	ras a consequence of): e renal fail:	iire				wk
_	and and II-tran	хап	that initiated events c.	or as a consequence of):	urc .				****
68760,	be e sician		Hype:	rtension					yrs
687	tificate be executed g physician and as the burial-transit	edical	d						
.O. Box	death cer e attendir ed for use	Physiclan/M	23b. Was decedent pregnant 1 Live bit	int at time of death 5	□Ectopic pregnancy □ Other (specify)			23d. Date of del Month	ivery Day Year
٩	that the led by th detache	y Ph	Part II. Other significant conditions contributing to de-	ath but not resulting in the	underlying cause given	in Part I.	23e. Did toba	cco use contribute to	the cause of death?
rds	w requires that s been signed t should be det	d by	Hypercalcemia, Hypokale	m <b>i</b> a			1 🗆 Yes	2 <b>3</b> No 3 □ Pr	obably 4 Unknown
Vital Record	G 2 C/	Completed	Malnutrition chronic ob	structive			24a. Was an autopsy performe	prior to	utopsy findings available completion of cause of
alE	an: The I tificate ha tor, page		Pulmonary Disease, chro	nic anemia		26. Place of Death	1 Yes 2		2LXNo
₹	sici	o Be	examiner?	patient 2 ER/Outpatie				ce 6 ☐ Other (Spe	cifv)
of	g Phy er this eral d	H	27. Manner of Death 28a. Date o			at 2	28d. Describe how		,,
<u>o</u>	Attanding Ist death. ector: After by the funer	atlo	2 Accident investigation	injury		es 2 🗆 No			
Division	그 분 분 ㄷ	Certification:		of Injury - At home, farm, s g, etc. <i>(Specify)</i>	treet, factory, office	2	28f. Location (Stre City or Town,	et and Number or Ri State)	ural Route Number,
	lospita t hours uneral	Medical C	29a. Certifier (Check only one)  29 Medical Examiner: On the based manner.	sis of examination and/or in	ith occurred at the time nvestigation, in my opin	n, date and place, a nion, death occurre	and due to the cau	ise(s) and manner as e and place, and due	s stated. a to the cause(s)
	To tha h within 24 To tha P complete	Mec	one) and mann 29b. Signature and title if certifier	1 /	29c. License	number	29	d. Date signed (Mont	h, Day, Year)
			Willin Keil	ly mp	D5474	9		2 - 24 -	2006
	WIL		30. Name and address of person who completed cause	e ath (Item 23a) (Type	a, Print)				
	4			11 House Av		Frederic	ck, MD	21701	
		ate	31. Date filed (Month, Day, Year) 32. Re	egiptrar's Signature					
	Regist	rar	FEB 2 8 2006	Gloseva S.	Doubles				

			1 - For State Registrar  1. Decedent's Name (First, Middl		ate of N	/larylar		artmen rtificat				lental Hyg	eg. No.	06	07977
	Physici	an	Helen		Marjo:	ri o	T.					Month	Day	Year	3. Time of Death
	/Medic Examir		4a. Facility Name (If not institution				J	4b. City	Town o	r Location o	of Death	February	7	2006 unty of Death	9:45A <sup>™</sup>
	Examili	lei	,												
	Funeral		Brooke Grove R 5. Social Security Number	enab at 6. Sex	nd Nu	<b>rsing</b> Age (In yis.	last birthday)	Olr If Under		If Under	24 Hrs.	8. Date of Birth		1tgome: 9. Birth	place (State or Foreign
	Director			1 M 2	F	84	Yrs.	Months	Days	Hours	Min.	May 10,	1921	Mar	yland
	pur *		Usual Residence of Decedent  10a. State  10b. County			10c Ci	ty, Town or Lo	cation							10d. Inside City Limits
	permit. Pages 1 end 2 should be filed within 72 hours efter death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28e-f show amount of the Item of the Item of the Item of It	tor		omery			Lver Sp								1 ☐ Yes 2 No
	with the	Completed by Funeral Director	10e. Street and Number 12606 New Hamps	hiro A	wenue			10f. Zip		20904		1	0g. Citizen	of What Cou	untry?
	eath	eral	11. Marital Status		as Deceder		IS 13	Was Darar			gin? (Sn	acify Vas or No.	14	Race · Amer	ican Indian
_	fter d	듄	1 Never Married 2 Mar	An	med Force:	s?				in, Mexican	, Puerto	ecify Yes or No- Rican, etc.)		Black, White	, etc.
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ה ה	72 ho natur	ed	15. Deceder (Specify only highe	t's Education			16a. Dece	dent's Usua	al Occup	ation during most	t of work	ina	16b. Kind	of Business/l	ndustry
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Maryland 21215-0036	ygier tt.	S	12				Home	maker	-					n Home	e 
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Š	J Mer narks	၉	Ernest Purcel				401 11 11		(2)			e Kraus			
	12 st h and 7 is n traun		19a. Informant's Name/Relations									al Route Number,			
e,	Heath		Marjorie E. Pra	ida / L	aught	20b. l	Place of Dispo	sition (Nar	ne of	L		larksvil		lary Lai ion - City or 1	
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ŭ	Depart Person		1 come	TI	Lu	Low	تب	1800	New	Hamps	shir	e Avenue	Silv	ver Sp	ring,MD
	Physician /Medical Examiner		23d Part1. Enten the disease, o shock, or bear failure. List Immediate Cause (Final disease or condition resulting in death)	only one cau	s that caus se on each Due to (or a	line. Art	terioso					or respiratory arre		2	Approximate Interval Between Onset and Death Years
,0070	icate be executed physicien and s the burial-transit	ical Examiner	Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	Due to (or a	is a consec		icer							
P.O. BOX 08/	the death certify the attending ached for use a	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	10	/es, outcom □Live birth □Pregnant □Unknown	2 Feta	al death 3	Ectopic pr Other (sp					23d.	Date of delive Month	very Day Year
	ires that signed to d be deta	6	Part II. Other significant condition	ons contributi	ng to death	but not res	sulting in the u	nderlying c	ause giv	en in Part I.			accoluse o		the cause of death?
Records,	law requir ss been si 2 should	Completed										24a. Was ar	1 2	4b. Were aut	opsy findings available
	ding Physicien: The the the the the the the this certificate he funeral director, page	Com									-	autops perform 1 Yes 2	ned?	death?	ompletion of cause of 2□ No
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	Ilng f After Iuner	0	27. Manner of Death 1 X Natural 5 ☐ Pendir		. Date of In (Month, D	Day Year)	28b. Time of Injury		8c. Injun			28d. Describe ho	w injury oc	curred	
DIVISION OF VITAL	Atten or deat actor; by the	Certification:	2 Accident investi 3 Suicide 6 Could 4 Homicide determ	not be	. Place of I	njury - At h etc. <i>(Speci</i>	ome, farm, str fy)	M eet, factory		Yes 2 □ 1		28f. Location (Str City or Town		umber or Rui	ral Route Number,
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	To the H within 24 To the Fi complete	fedical	Gire)	al	n the basis nd manner :	stated.	allon allower in				un occurr	ed at the time, da			
	To To To To To To To To To To To To To T	Σ	29b. Signature and title of certifie				( )	290	. License	e number		25	d. Date si	gned (Month	, Day, Year)
	5		/ Joya	- XV	un	-, 1				D083	81		Fel	oruary	27, 2006
			30. Name and address of person  Benjamin A						lio	Dr. O	1nev	, MD 208	32		
	Sta Registr		31. Date filed (Month, Day, Year)  MAR 0 1			strar's Sign		orke)						-	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrer Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day P.M. 25 2006 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death FEDINSULA REGIONAL
5. Social Security Number NICOM IND Medical SALISBUM CONTG If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex 8. Date of Birth (Month, Day, Year) Months Days Hours 1 ☐ M 2 🔀 F 2/2-66-1334 1-16-55 Usual Residence of Decedent 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits Yes 2 No MD DCESTER 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 500-21863 USA VE 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status Was Decedent Armed Forces Ever in U.S. 1 Never Married 2 ☐ Married ☐Yes 2 No 1 ☐ Yes 2 No BLACK Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) STODIAN 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) SHOCKLEY DORETHA HEODOBE WKINS DAUGHEA 9b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip lode) 19a. Informant's Name/Relationship (Type, Print) 304A-PURNELL ST. IN Date 20c. Lo AW KAMESHA ~GOZGHOL MD 21863 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Los tion - City or Town, State 20a. Method of Disposition 1 ☐ Surial 2 ☐ Cremation 3 ☐ Removal from State SHOW HILL HUTTS MEMORIAL 06 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License SMITH FIH 22. Name and Address of Facility BENNIE 917 W.I SABELLA ST SALISBURY MD 21801 Nisci Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) heart failure Acute decompensated Due to (or as a consequence of) STLKYE cell crisis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 4☐Pregnant at time of death 5 Other (specify) 9□ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

The lew requires that the death certificate be executed physicien and s the burial-trans Box 68760. the attending p ö ģ σ. been signed b Records, cate hes page 2 s certificate Vital director, ð this After this funeral c Division deeth. efter

**Physician** 

/Medical

Examiner

**Funeral** 

Director

rthan "natural", or Itams 23a or 28a-f ahow the Madical Examinar must be notified at

permit. Pages 1 and 2 should be filed within 7. Depertment of Health and Mental Hygiene. Important: If Itam 27 is marked other than "na any Injury or other traumatic avant, the Madia one.

Physician /Medical

Examiner

Examiner

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Certification:

Medical

4 Homicide

29a. Certifier (Check only one)

Baltimore,

72 hours after

Director

Funeral

Completed by

Be

To the Funeral Director: completely filled in by the the Hospital or within 24 hours e To the Funeral I

> State Registrar

d title of certifier 29b. Signature

determined

29c. License numbe H50497

1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year) 3/1/06

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated

Chrisophen Swyder 100 E. CARROLL ST. SAlisbury Md

31. Date filed (Month, Day, Year) MAR 0 1 2006 32. Registrar's Signature

		ľ	State of Sta	f Maryland / D		rtment of H		Mental Hy	giene Reg. No.	06	07979
I	Physicia	an	1. Decedent's Name (First, Middle, Last)					2. Date of Di Month	Day	Year	3. Time of Death
	/Medic		Dennis Reed Koenig				1 66 18	Februa		, 2006	1:15 AM
	Examin	er	4a. Facility Name (If not institution, give street and nu Shady Grove Adventist Ho			4b. City, Town, or Rockvill		tn .	4c. County of Death  Montgomery		
Н		-	5. Social Security Number 6. Sex	7. Age (In yrs. last birt	thdav)	If Under 1 Year		8. Date of Bi	rth		place (State or Foreign
	Funeral Director		260-74-6015 ¹፟Xìм 2□F	<del>-</del>	Yrs.	Months Days	Hours Min	(Month, D	9, Year) 19, 19.	Cour	ington, D.C
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	the N	rect	Maryland Montgomery  10e. Street and Number	Gaithers	spui	10f. Zip Code			10a, Citize	n of What Cour	ntry?
	oth with the Marylan 23s or 28s-f show ust be notified	Funeral Directo	124 E. Deer Park Drive			20877			USA		
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8	or It	by Fu	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes	2 <b>X</b> No /e		☐Yes 2X No		, , , , , , , , , , , , , , , , , , , ,			
Ş	hours ture!	q pa	3 ☐ Widowed 4 ☐ Witorced Year or D  15. Decedent's Education		Deced	ent's Usual Occup	ation			Whi	
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	nould be to marked of natic eve	၉	George Donald Koenig	40)	A A - 717 -		Lois Ca				0.11
Mar	d 2 st th and 17 le n traun		19a. Informant's Name/Relationship (Type, Print) Gary D. Koenig/brother			Address (Street) Deer Pa					
	as 1 and 2 should of Health and Me litem 27 le mark r other traumation		20a. Method of Disposition	20b. Place of	Dispos	ition (Name of atory or other place	Mar	chatel,	20c. Loca	ition - City or To	own, State
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Baltimore,	permit. Pages Department of I Importent: If Ite eny injury or of		21. Signature of Funeral Service Licensee	11	22. GG	Name and Address	ss of Facility	ion Serv	ice I	P.O. Bo	x 784
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<u>ra</u>		a)	25. Was case referred to medical				26. Place of De	1 ☐ Yes ath (Check only	one)	1 ☐ Yes	2 No -
	ysici is cer direc	To B	examiner? 1 Yes 2 No Hospital:	Inpatient 2 ☐ ER/Out	tpatient	3□ DOA Oth	00	Home 5 ☐ Res		Other (Specif	(y)
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			) USER B BALL	MD			7117		ISDA	vary:	28 2406
)0	lð.		30. Name and address of person who completed cau	frederick		45	s GAIT	herbu	· Ja	15 20	877
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State of Maryland / Department of Health and Mental	Hygiene	001	6
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Physicia /Medic Examin	ľ
Funeral Director	

		•	State Registrar			Cen	tificate of t	Deat	h		Reg. No.			
	ķ.		1. Decedent's Name (First, Middle, Last)							2. Date of De Month	ath Day	Year	3. Time of Death	
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	/Medic Examin		4a. Facility Name (If not institution, give st.	reet and number)			4b. City, Town, o	r Locatio				ounty of Death		
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	Funeral		5. Social Security Number 6. Sex		e (In yrs. last bi	rthday)	If Under 1 Year Months Days	If Und	der 24 Hrs.	8. Date of Bir	th v. Year)	9. Birthp	place (State or Foreigntry)	n
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	D		Usual Residence of Decedent		10+ Cit. T-								I0d. Inside City Limits	-
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	tems tems	Funeral	11. Waritan Otatos	2. Was Decedent Armed Forces	)	13. W	as Decedent of H Yes, specify Cuba	lispanic an, Mexi	Origin? (Spe can, Puerto I	City Yes or No Rican, etc.)	)-   ''	<ol> <li>Race - Americ Black, White,</li> </ol>		
36	be filed within 72 hours after death with the Maryland ital Hygiene. bd other then "natural", or tiems 23a or 28a-f show event, the Medical Examinar must be multiled at	by F	1 Never Married 2 Married 3 Widowed 4 Divorced	1 AYes 2 If Yes, Give	1982 <b>–</b> 87	, 1	☐ Yes <b>Ž</b> ŽNo	Spec	eify:		5	Specify: Wh	ite	
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7	should be nd Mental marked (	_	19a. Informant's Name/Relationship (Typ	e, Print)	19	b. Mailin	g Address (Street	and Nu	mber or Rura	l Route Numb	er, City or	Town, State, Zij	Code)	
	nd 2		Charlotte Klee/Frie	nd	5	06 I	arksdale	e Ro	ad. Jo	ppa, M	D 210	85		
Ĉ,	s 1 a f Hez item othe		20a. Method of Disposition		20b. Place	of Dispos	sition (Name of natory or other plan			ate		ation - City or T	own, State	
30	Page ent o nt: If ry or		1 ☑ Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	moval from State			ge Cemete		3/04/	2006	Thur	mont, M	D	
Baltimore,	Dartm Corte	. 11	21. Signature of Funeral Service License			22	. Name and Addre	ss of Fa	acility Sta	uffer	Funer	al Home	, PA	Π
ä	permit. Pages 1 and 2 should by Department of Health and Menta Importent; if Item 27 is marked any injury or other traumatic ev		foculture.			10	)4 E.Mair	n St	reet,	Thurmo	nt, M	D 21788		
			23a. Part. Beer the disease, or complice shock, or heart failure. List only one	ations that cause	d the death. Do	not ente	er the mode of dyli	ng, such	as cardiac c	r respiratory a	ırrest,		Approximate Interval Between	
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	the I the I	ded	one)	and manner s	stated.		29c. Licen	sa numi	ner .		29d Date	signed (Month	Day Year	
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	11/17		Mus					OC	ME		Marc.	h 1, 20	Jb	_
1	(0x10.		30. Name and address of person who co		death (Item 23a	ı) (Type,		י מוני	Street	R=1+-	imore	Marzol	and 21201	
	-01	240	31. Date filed (Month, Day, Year)	32 Ba	trar's Signature			-1111	CLCCL		Linore	, у 10	**************************************	
	St Regist	ate rar	MAR 0 3	006	Mere 1	y ,	Soule							
						-	<i></i>							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month 0230 Stephen Kodges Francis February 27, 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel 2901 Cold Spring Way #425 Crofton 8. Date of Birth (Month, Day, Year) 5. Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 187-42-9843 53 Director August 26,1952 Pennsylvania Usual Residence of Decedent 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits 1 ☐ Yes 2 No Director Crofton Anne Arundel Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2901 Cold Spring Way #425 United States 21114 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 XYes 2 No If Yes, Give 1970 Year or Dates: 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 No Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Superintendant Comercial Construction 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Edward Kodges Rose Jardina 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2901 Cold Spring Way #425 Crofton, MD. 21114 Rebecca A. Kodges (wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition February 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 28, 2006 Alexandria, Virginia 21. Signatur i or i uni ral Service Licensee 22. Name and Address of Facility Advent Funeral & Cremation Service, Inc. M00982 42 Hudson St. Suite 110 Annapolis, Maryland 21401 23a. Part1. Enter the disease, or com shock, or heart failure. List only or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 2 mor Due to (or as a consequence of) Examiner

**Physician** /Medical Examiner

certificate be executed

Box 68760,

Division of Vital Records, P.O.

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ir then "natural", or iteme 23a or 28a-f ehov the Medical Examiner must be notified at

other then

permit. Peges 1 end 2 should be filed Deperment of Health and Mental Hygi Important: if Item 27 is marked other eny injury or other traumatic event, I

within 72 hours after

Baltimore, Maryland 21215-0036

physicien and the burial-transit Physician/Medical for use as the signed by t d be detach à es been sig Be Completed page After this certificete funeral director, pag ဥ Certification: To the Hospital or Attendin within 24 hours effer death.
To the Funerel Director: Att completely filled in by the fur

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Sequentially list conditions, if any, leading to intimediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consect Due to (or as a consect d.					
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Part II. Other significant conditions of	ontributing to death but not re	sulting in the underlying	, cause given in Part I.	23e. Did tobacco  1  Yes 2  24a. Was an autopsy performed? 1 Yes 2	24b. Were autopsy findin prior to completion of death?	Unknow
25. Was case referred to medical examiner?	Hospital:		Other	eath (Check only one)		
1 Yes 2 No 27. Manner of Death		28b. Time of	DOA 4 Nursing	Home 5 Residence		
1 Natural 5 Pending 2 Accident investigation		Injury	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	20d. Describe now inju	ary occurred	
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At h building, etc. (Speci	ome, farm, street, fact fy)	ory, office	28f. Location (Street a City or Town, State	nd Number or Rural Route N te)	lumber,
29a. Certifier (Check only one) Certifying Ph	ysician: To the best of my kniner: On the basis of examination and manner stated.	owledge, death occurre ation and/or investigati	ed at the time, date and place on, in my opinion, death occ	e, and due to the cause(surred at the time, date an	s) and manner as stated. nd place, and due to the caus	ie(s)
20h Signature and talle of contilier	^ // \		On Lineage sumber	1104 0	ate signed (Month Day Van	-1

State Registrar

City 31. Date filed (Month, Day, Year)

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Signature and title of certif.

strar's Signature 2006

se of death (Item 23a) (Type, Print)

			1 - For State Registrar		ryland / Depa		lealth and M	lental Hygie	_	07983
	Physic	ion	1. Decedent's Name (First, Middle, L					2. Date of Death Month	Day Year	3. Time of Death
	Physic /Medi		Julia Anna Ke					February	27, 2006	1:05 AM M
7	Exami	ner	4a. Facility Name (If not institution, gi	ve street and number)			Location of Death		4c. County of Death	
			Oak Crest Village			Parkvi1			Baltin	
	Funeral Director			Sex 7. Age	(In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y	ear) 9. Birth Cou	place (State or Foreign ntry) Mary I and
	show		10a. State 10b. County		10c. City, Town or Lo	cation				10d. Inside City Limits
	the Mar 28a-f sh	tor	MD Baltim	ore	Parkville					1 ☐ Yes 2 ☒ No
	death with the Maryland ms 23a or 28a-f show Livast by rutified at	Funeral Director	10e. Street and Number			10f. Zip Code		10g	. Citizen of What Cou	ntry?
3	ath w	ra	8832 Walther Bou	levard		21	234		United State	es .
	after dea or Items	nne	11. Marital Status	12. Was Decedent E	1	Was Decedent of Hi f Yes, specify Cuba	ispanic Origin? (Spe n, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ameri Black, White,	can Indian, etc.
36	rs aft	by F	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 🕅 No If Yes, Give Year or Dates:		1□Yes 2⊠No	Specify:			ite
21215-0036	2 hou	ed	15. Decedent's 8		16a. Dece	tent's Usual Occupa	ation	16	b. Kind of Business/In	dustry
215	nin 72 nin "ni	Completed	(Specify only highest gi	ade completed) College (1-4or 5+	(Give	kind of work done of OO NOT use retired	during most of worki	ng	b. Ithia of Dashiossii	dustry
21	d with	m o	Elementary/Secondary (0-12)	College (1-401 5+		keeper			County Gover	nment
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yla	Ment Ment arke	2	Frank C. Kearns				Catheri	ne M. Barre	ett	
Maryland	2 sh and is m		19a. Informant's Name/Relationship						city or Town, State, Zip	Code)
e,	1 and Health sm 27 ther t			Niece	3009 N 20b. Place of Dispo		, Baldwin, I			
Baltimore,	permit. Pages 1 and 2 should be filled within 72 hours after de Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items any injury or other traumatic event, the Medical Energher 2006.		20a. Method of Disposition 1 Denial 2 Cremation 3		cemetery, cren	natory or other place	9)		c. Location - City or To	
를	it. Partitude		<ul><li>4 □ Donation 5 □ Other (Special Signature of Funeral Service Lice</li></ul>	**	Carroll Cre			ry 28, 2006	Hampstea	d, MD
Ba	Department Department of the suny in the sun in the sun		21. Signature of Purieral Service Lice			. Name and Addres		Inc 260 En	edonick Stro	et, Hanover, F
	Physician: The law requires that the death certificate be executed to the standard physician and this certificate has been signed by the attending physician and injoin all director, page 2 should be detached for use as the burial-transit as a second process.	dical Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a	consequence of):  consequence of):	(4mb)	noma			Onset and Death
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Vital Records, P	ruires that signed b	by	Part II. Other significant conditions	contributing to death but	not resulting in the un	derlying cause give	n in Part I.		co use contribute to the	
000	s been si should	Completed						24a. Was an	24b. Were auto	psy findings available
Re	The lav	шо						autopsy	prior to co	mpletion of cause of
ita	aiclan: Th certificate irector, pag	a	25. Was case referred to medical				26. Place of Death	Check only one)	No 1 □ Yes	2 No
f V	nyaic nis ce direc	ToB	examiner? 1  Yes 2 No	Hospital: 1 Inpatient	2 ER/Outpatient	3□ DOA Othe			e 6 Other (Specific	v)
	ding I. After fune		27. Manner of Death 1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation		Year) 28b. Time of Injury	28c. Injury Work M 1 \(\supers		8d. Describe how i		,
Division	e Hospital or Attenc 24 hours after death 9 Funeral Director: etely filled in by the i	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc.	y - At home, farm, stre (Specify)	et, factory, office	2	8f. Location (Stree City or Town, S	t and Number or Rura State)	l Route Number,
	To the Hospital or within 24 hours after to the Funeral Director Completely filled in	Medical	29a. Certifier (Check only one)	nysicien: To the best of miner: On the basis of e and manner state	xamination and/or inv	occurred at the time estigation, in my op	e, date and place, a inion, death occurre	nd due to the caus d at the time, date	e(s) and manner as st and place, and due to	ated. the cause(s)
	To the I within 2. To the I complete	Σ	29b. Signature and title of certifier			29c. License	number	29d.	Date signed (Month,	Day, Year)
ř	(10i)		ann	and		0581	046	Fe	bruasy	27 2006
	0,0		30. Name and address of person who	completed cause of dea	th (Item 23a) (Type, F	Print)		Th.		
			Anna Monia 5 31. Date filed (Month, Day, Year)	8 800	walthe	- Boul	(proved)	Parkerill	e MD2	1234
	Sta Registr		FEB 2 8	2008 2008	s signature	perti			bruary he MD 2	:

Julia leercas

			1- For State Registrar Amend Items	State of Man 23a,b,25,	vland / Dep 27,28act	artment rifficate	of Health ar		183 1/2 1/2	6	07984
	Physici /Medic		1. Decedent's Name (First, Middle, Last)  FLOYD E. LEAD	FRS, JR				2. Date of De Month	Day	Year	3. Time of Death 05'4-5 AM
ġ)	Examir		4a. Facility Name (If not institution, give str		ITAL		own, or Location of	Death	4c. County	of Death	につ
	Funeral Director		5. Social Security Number 6. Sex 479–34–3474	7. Age (I	n yrs. last birthday) 74 Yrs.	If Under 1 Months	Year If Under 24 Days Hours		th Year) 931	9. Birthpi Coun I owa	lace (State or Foreign try)
	aryland show	'n	Usual Residence of Decedent  10a. State  10b. County		Oc. City, Town or Lo		-			10	0d. Inside City Limits 1 XYes 2 ☐ No
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	th with 23a or	al Di	9529 Ash Hollow Pla	ce		20	0886-1239		United S		
920	be filed within 72 hours after death with the Maryland thygiene. d other then "netural", or flems 23e or 28e-f show event, the Medical Eracifier must be notified at	by Funeral	11. Marital Status 12 1 Never Married 2 Amarried 3 Widowed 4 Divorced	Was Decedent Eve Armed Forces? 1 XYes 2 No If Yes, Give KO Year or Dates:		Was Decede	y Cuban, Mexican, I	n? (Specify Yes or No Puerto Rican, etc.)		e - Americ ck, White, c	
21215-0036	e filed within 72 ho al Hygiene. I other then "netur vent, I're Medical	Completed	15. Decedent's Educal (Specify only highest grade of Elementary/Secondary (0-12)		(Give	DO NOT use	done during most of	f working	Botanic Pharmac Company	cal ceuti	
nd	al Hygie I other	Be C	17. Father's Name (First, Middle, Last)				18. Mother's	Name (First, Middle,			
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	日本など		19a. Informant's Name/Relationship (Type Madeline Carol Van	•	1			or Rural Route Numberce, Montgo	-		
CI3	Pages 1 ar nent of Hea int: If item iry or othe		20a. Method of Disposition 1 □ Burial 2 弦Cremation 3 □ Ren 3 □ 3 □ 3 □ 3 □ 2 □ 3 □ 3 □ 3 □ 3 □ 3 □		20b. Place of Dispo cemetery, cree Metropo Cremato	sition (Name	e of	bruary 27	20c. Location - Alexan Virgi	Gity or Too dria,	
Balti	permit. Pages 'Department of H Importent: If ite any njury or of once.		21. Signature of Funeral/Service Dicensee	M0068	22	2. Name and	Address of Facility		neral Ho	ome,	, MD 20877
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	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	SEPT Due to (or as a co		ZIC .					48 405
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ds, P.	rres tnat in signed by t I be detach	ру Р	Part II. Other significant conditions contril	outing to death but n	ot resulting in the u	nderlying cau	use given in Part I.				e cause of death?
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1	vithin 2 To the complete	Me	29b. Signature and title of certifier				License number		29d. Date signed	•	*
2	4+1		1 Dandleyon	ym			D36970		FUB	26 2	2006
_			30. Name and address of person who comp	leted cause of death	(Item 23a) (Type,	Print) Day	vid Nyanjo	on, M.D. Zioqe			
•	Sta Registr		31. Date filed (Month, Day, Year) MAR 0 1 2006		Signature	J. S. S. S. S. S. S. S. S. S. S. S. S. S.					

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		- 9),	Decedent's Name (First, Middle	e, Last)							2. Date of De	ath		· · · · · ·	3. Time of D	Death
	Physici /Medic		William 3	Joseph	Mills	S					Month March	3, 2	2006	Year	12:28	р.М.
	Examin		4a. Facility Name (If not institution	n, give street and nu	mber)		4b. City	, Town, or	Location o	f Death			County o	f Death		
			St. Mary's Hos						onard						ary's	
	Funeral Director		5. Social Security Number 220-40-3147	6. Sex 1 MM 2 □ F	7. Age (In yrs. 64	last birthday) Yrs.	Months Months	Days	If Under 2 Hours	Min.	8. Date of Bin (Month, Da June 22	$\frac{1}{y}$ , $\frac{Y}{\theta}$	941	Cou	olace (State or ntry) yland	Foreign
	and		Usual Residence of Decedent  10a. State 10b. County		10c. Cit	ty, Town or Lo	cation								10d. Inside City	/ Limits
	Manyl f sho	ō	Manage 1 am 1 Ch	Marrita			T - 0-								1 ☐ Yes	
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	h with	a D	40315 Wathen I	Road				206	650			Unit	ed S	tate	25	
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98	or ite	F.	1 XNever Married 2 ☐ Marr	ned 1 ☐ Yes If Yes, Gi	2 <b>X</b> No			2 X No		, 7 00110 1	noarr, sto.,		Specify:			
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P.O. Box (	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the buriat-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 Live b	tcome of pregna pirth 2 Teta nant at time of d lown	Ideath 3	]Ectopic β ] Other (s	pecify)				:	23d. Date Mont			ear
	uires that signed b	by	Part II. Other significant condition	ons contributing to d	eath but not res	sulting in the u	nderlying	cause give	en in Part I.		23e. Did to				he cause of de	
CO	w requir been si should	lete	1442161	とりらしん	_						24a. Was	an	24b. W	ere auto	ppsy findings av	vailable
Re	The lav	Completed	Chanic laypoin corner	r artec	× d15	east					autop	rmed?	pri de	or to co ath?	mpletion of cau	use of
ita		BeC	25. Was case referred to medical						26. Place	of Death	1 Yes	2 No	1	Yes	2 No	
<u></u>	Physician: this certific ral director.	To E	examiner? 1 ☐ Yes 2 ☐ Yo	Hospital: 1	npatient 2	ER/Outpatier	it_ 3□ D	OA Othe			e 5 Resid		6 🗆 Other	(Specif	y)	
0 _	ng Pt fter th		27. Manner of Death  1 Natural 5 □ Pendin	28a. Date	of Injury th, Day Year)	28b. Time of Injury		28c. Injury Work	at ?	28	8d. Describe h	now injur	y occurre	d		
sio	Attending Physician: r death. sctor: After this certific by the funeral director.	cati	2 Accident investig	pation		<u> </u>	М		/es 2 □ N							
Division of Vital Records,	ital or At rs after or al Dirac led in by	Certification:	4 Homicide determ	inod 288. Place	of Injury - At he ing, etc. (Specif	ome, farm, str	eet, facto	y, office		2	8f. Location (S City or Tov			or Rura	al Route Numb	ΘΓ,
	To the Hospital or Attending I within 24 hours after death. To the Funeral Diractor: After completely filled in by the funer	Medical	29a. Certifier 1 Certifyin (Check only one) 1 Medical	g Physician: To the Examiner: On the b and man	a best of my kno as is of examina ner stated.	owledge, death ttion and/or in	occurred vestigation	at the tim	e, date and inion, deat	l place, ai h occurre	nd due to the d d at the time,	cause(s) date and	and mani place, an	ner as s id due to	tated. the cause(s)	
	To t To t	Σ	29b. Signature and title of certifier	arm			29	c. License	number		$\sim$	29d. Dat	e signed	(Month,	Day, Year)	
			(01)				7	XX	100	71	9	Marc	h 3,	200	)6	
			30. Name and address of person						D	77 ~	1	3.5	4	4 6	0000	
77	Sta	te	Dhananjay V. Bh 31. Date filed (Month, Day, Year)	32. F	D., 240 Registrar's Signa		ree N	otch	Koad,	, Hol	ywood	, Ma	ryla	nd 2	20636	
	Registr		MAR O		Between		Treat	60								

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) 3. Time of Death Day **Physician** Month Year 2006 10:10p<sup>M</sup> March 1, <u>Gilbert E. Mackie</u> /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 203 Fletchwood Rd. Elkton Ceci1 if Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☑ M 2 ☐ F Yrs. 215-58-3535 54 Director January 16,1952 MD Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r than "netural", or items 23a or 28a-f show the Medical Examinar must be notified at 1 ☐ Yes 2 TNo Director MD Ceci1 E1kton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 203 Fletchwood Rd. 21921 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status permit. Pages 1 and 2 should be filled within 72 hours after Department of Health and Mental Hygiene. Infortant: if item 27 is marked other than "netural, or ite mortant: if item 27 is marked other than "netural, or ite any injury or other traumatic event, the Medical Examina once. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 25 Married Baltimore, Maryland 21215-0036 ģ Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Manufacturing Machine Operator 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Gilbert B. Mackie Marie Mackie Hamm 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 203 Fletchwood Rd., Flkton, MD of Disposition (Name of Date Date 20c. Location - C Genese Mackie/Wife 21921 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 🛱 Burial 2 ☐ Cremation 3 ☐ Removal from State March 6, Elkton, Elkton Cemetery ` 4 ☐ Donation 5 ☐ Other (Specify) 2006 21. Sin alura of Service Licensee 22. Name and Address of Facility Andrew G. Gee Funeral Home 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or reshock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Elkton, Immediate Cause (Final disease or condition resulting in death) Physician Jungton unk /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine anding physician and use as the burial-transit certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE. 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant signed by the atten d be detached for u 3 Ectopic pregnancy in the past 12 months? Day 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed been 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No this certificate has 1 Yes 2 → No Hospitel or Attending Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner Hospital: 1 Inpatient Other: 4 Nursing Home 5 Sesidence 6 Other (Specify) 1 ☐ Yes V No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After 5 Pending Natural death. 1 ☐ Yes 2 ☐ No investigation 2 Accident thours after death 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide To the Hospitel within 24 hours a To the Funeral D 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 3/2/2006 D54086 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) (0 High St., Elkton, mo 21921 111 W Khatri 31. Date filed (Month, Day, Year)
MAR 0 3 2006 Registrar's Signature State Registrar

			1 - For State Registrar	State of M	laryland / I	•	rtment tificate			and M	ental Hy	/giene Reg. No	UU.	6	07987
	Dhusiai		1. Decedent's Name (First, Middle, Last)								2. Date of D Month	Da	v	Yeer	3. Time of Death
	Physici /Medic		Michael Wayı	ne 	Meadows	, J:	r.				Februa			006	1332 <sup>M</sup>
	Examin	er	4a. Facility Name (If not institution, give s				4b. City, T			f Death		4c.	County	of Death	
		×	Anne Arundel Medio				Ann If Under 1	napo]	Lis If Under:	24 Hro			Anne		
	Funeral		5. Social Security Number 6. Sex	M 2□F 7. A	ige (In yrs. last bi	rthday) Yrs.		Days	Hours	Min.	8. Date of B	ay, Year)			lace (State or Foreign try)
	Director		none Usuel Residence of Decedent				L		16	38	Feb. 2	20,20	06	Mary	Land
	/land		10a. State 10b. County		10c. City, Tow	m or Loc	ation							1	0d. Inside City Limits
	Man Hist	ţ	MD Anne Arui	nde1	Glen	Buı	rnie								1 ☐ Yes 2 🎇 No
	r 28g	Director	10e. Street and Number				10f. Zip C	Code				10g. Cit	izen of W	hat Cour	itry?
	th wit	a D	1710 Lansing Road				21	1060					USA		
	dea	Funeral	11. Marital Status	2. Was Deceden Armed Forces	t Ever in U.S.	13. V	Vas Decede	nt of Hisp	anic Orig	gin? (Spe	cify Yes or N Rican, etc.)	0-		- Americ	an Indian,
õ	hours after death with the Maryland turel', or Items 23a or 28a-1 show al Examiner must be notified at	F	1X Never Married 2 ☐ Married	1 ☐ Yes 2X If Yes, Give		1	□ Yes 2		Specify:	,	,,		Specify:		hite
9500-61212	urat',	d by	3 Widowed 4 Divorced	Year or Dates								1			
γ	nat nat	Completed	15. Decedent's Educ (Specify only highest grade	completed)	16a	(Give I	ent's Usual kind of work ONOT use	done du		of worki	ng	18b. K	ind of Bus	siness/Ind	dustry
2	withir ene. then	m d	Elementary/Secondary (0-12)	College (1-4or		/A	O NOT DSC	1011100)					N/A		
מ	be filed within 72 hours after death with the Marylan ital Hygiene. id other then "natural", or Items 23s or 28s-1 show other then "natural", or a went, the Micrical Examiner must be multised at		17. Father's Name (First, Middle, Last)			/A		1	8. Mothe	r's Name	(First, Middle			a)	
a	should be filed and Mental Hygi marked other imatic event, I	To Be	Michael Wayne Mead	lows				N	licho	le I	ynn Gi	11			
Maryland		-	19a. Informant's Name/Relationship (Typ		198	. Mailin	g Address (				l Route Numi		or Town, S	State, Zip	Code)
_	1 and 2 Health a tem 27 le		Michael Meadows (1	Father)	1	710	Lansi	ing R	load,	G1e	n Burn	ie,	MD 2	1060	
e j	of He item		20a. Method of Disposition		20b. Place o	t Dispos	sition (Name	e of ner place)		C	ate	20c. Lo	ocation - (	City or To	wn, State
Ĕ	Pages nent of ant: If it ary or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ Re  '4 ☐ Donation 5 ☐ Other (Specify)	emoval from Stat	Metro	Cre	emator	у		3-3-	2006	Ba1	timo	re, l	MD
Baitimore,	permit. Pages Department of I Important: If it any injury or o		21. Signature of Funeral Service Licence	9		22.	Name and	Address	of Facility	ra1	Home,	Р. А.			
n —	90 = 9		18 1.4	~			12 Ri	dge1	y Av	enue	, Anna	poli	s, M	214	401
á			23a. Part1. Enter the disease, or complete shock, or heart failure. List only on	cations that cause e cause on each	ed the death. Do line.	not ente	r the mode	of dying,	such as	cardiac o	r respiratory	arrest,			Approximate Interval Between Onset and Dgath
	Physician		Immediate Cause (Final disease or condition	Cxtr	eme	Pr	emo	tu.	rit	4					one day
	/Medical Examiner		resulting in death)	Due to (or a	s a consequence	of):									0
	Je., 25	-	Sequentially list conditions.	Due in for a	s a consequence	ດນີ້:									
	bet nsit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	200.00 (0. 0	- L	0.7.									
,	n and	Exal	that initiated events c resulting in death) Last	Due to (or a	s a consequence	of):								-	
8/60	death certificate be executed e attending physician and id for use as the burial-transit	dical	d											1	
9	tifical ng ph as th	Medi	15.55111.5												
ROX	eath certifi attending I I for use as	an/N	230. Was decedent pregnant	3c. If yes, outcom 1 ☐ Live birth	e of pregnancy 2 Petal death	3 □	Ectopic pre	gnancy					23d. Date		
4	e dea he att	sici	in the past 12 months? 1  Yes 2 No		at time of death		Other (spe-						Mon	(n	Day Year
r Ö	law requires that the de as been signed by the a 2 should be detached	Physician/Me	9 Unknown  Part II. Other significant conditions con	tributina ta daath	but not regulting	a tha ua	darkuna aa		in Dont I		23a Did	tobacco	rea constri	bute to th	ne cause of death?
က်	ires tha signed I I be det	by	Constant TV Total	C. KO LA	to contract of		11.		- 2- 0	0.0			\_		ably 4 Dunknown
Kecords,	w require been sign	Completed	Grade 10 Int	0 1	ricara		llen	non	C	Te		-		-	
ec ec	e law has b	Jdu	Clir Leak	Synd	rome		- 1				24a. Wa		pr	ere autori for to coreath?	psy findings available npletion of cause of
	i <b>cian</b> : The la certificate has rector, page 2		Respiratory	Distr	~55	Sxr	ndr	om	e		1 ☐ Yes	2 2000		☐Yes	2540
VII		Be	25. Was cas referred to medica examiner?	ospital:			-500	Other			(Check only				
ō	Phys r this ral di	1: To	1 Yes 2 No	28a. Date of In	jury 28b.	Itpatient Time of	-	c. Injury a	t Nu	-	ne 5 🗆 Res 28d. Describe				/)
0	nding th: : Afte	to	1 SNatural 5 ☐ Pending 2 ☐ Accident investigation	(Month, D	lay Year)	Injury	М	Work? 1 ☐ Ye	s 2 🗆 l	No					
DIVISION	Atter r dea ector by the	ifice	3 Suicide 6 Could not be determined	28e. Place of li	njury - At home, fa	arm, stre	et, factory,	office		2	28f. Location City or To			r or Rura	l Route Number,
ā	s afte	Certification:	4 - Homeide	burding, e	etc. (Specify)						City of To	iwii, State	*)		
	To the Hospitel or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer	edical (	29a. Certifier // Check only one) // Check only one) // Certifying Phys 2   Medical Examin	er: On the basis	of examination ar										
	o the ithin a o the orple	Med	29b. Signature and title of certifier	and manner s	olaleu.		29c.	License r	number			29d. Dai	te signed	(Month,	Day, Year)
	F 3 F 8		14/				-	10	716	-A		7.1		. ,	21 2006
/ (	J.H		39. Name and address of person who cou	mpleted cause of	death (Item 23a)	(Type F	Print)	14	//->	U	ŀ	760	rua	y	1) -000
7.7			V	unn Lin	, MD		2001	Me	dia	1 P	tay, o	Inna	pulis	M	d 21401
al.	Sta		31. Date filed (Month, Day, Year)		trar's Signature	0	(12.27)				1	,			
	Registr	ar .	MININ O T SOOL			Charle	2012								

			1 - For State Registrar	State of Maryla			of Health and of Death		iene 0 06	07988
	Physic /Medi		Decedent's Name (First, Middle, Last)		itchell			2. Date of Death Month February	h Day Year	
	Exami		4a. Facility Name (If not institution, give s Holy Cross Hospit	treet and number)			m, or Location of De er Spring		4c. County of De	ath
	Funeral Director		5. Social Security Number 6. Sex 214-96-7152	7. Age (In yi	rs. last birthday) Yrs.	If Under 1 Y Months Da	ear If Under 24 H ays Hours Mi		Year) 9. Bi	inthplace (State or Foreign Sountry) Louisiana
	72 hours after death with the Maryland natural', or Items 23a or 28e-f show alcal Examinut must be notified at	rector	10a. State 10b. County  Florida  10e. Street and Number	10c. 6	City, Town or Lo		etersburg	10	ng. Citizen of What C	10d. Inside City Limits 1X Yes 2 □ No
	death with ms 23a or	erai Di	2827 Park Street	2. Was Decedent Ever in	U.S. 13. V	33'	710		USA 14. Race - Am	
9000	72 hours after on the natural, or Ite	d by Fur	1 ☐ Never Married 2 Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 [] Yes 2 图 No If Yes, Give Year or Dates:		f Yes, specify (		(Specify Yes or No- erto Rican, etc.)	Black, Wh	
21215-0036	within ene. then "	Completed by Funeral Director	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12) 8th		(Give	DO NOT use re	one during most of w tired)	rorking	6b. Kind of Business	
Maryland 2	ld be filed ental Hygi ked other ic event, I	To Be Co	17. Father's Name (First, Middle, Last) Willie Mitchell			IISLIUCI		ractor ame (First, Middle, M Rosie Mitc		ate
	d 2 sho		19a. Informant's Name/Relationship (Type Sonny Mitchell	ee, Print) (Son)				Rural Route Number,		
Baltimore,	S to I D		20a. Method of Disposition  1 ☑ Surial 2 ☐ Cremation 3 ☑ Re 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	cemetery, cren	natory or other  Cemet	ery 3/3	/2006 J	oc. Location - City of acksonvil	le, Florida
Bai	permit. Pag Department Important: h eny injury o		21. Signature Juneral Service License	Sente	9	013 Anr	apolis Ro	endon/Hale bad, Lanhar	Funeral F n MD 20706	Home
ı	Physician /Medical		23a. Part1. Enter the disease, or complications, or heart failure. List only one timediate Cause (Final disease or condition resulting in death)	Sepsis		er the mode of	dying, such as cardi	ac or respiratory arres	st,	Approximate Interval Between Onset and Death
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, 0,	cate be executed physicien and the burial-transit	i Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Coronary Due to (or as a conse	quence of);		·			
x 68760,	ertificate b ling physic ie as the b	Medical	d.	_ Chronic O		ive Pul	monary Di	sease		
.O. Box	that the death certific ed by the attending p detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown	c. If yes, outcome of pregr 1 Live birth 2 Fel 4 Pregnant at time of 9 Unknown	tal death 3 🗌	Ectopic pregna Other (specify,			23d. Date of de Month	livery Day Year
ords, P	The law requires that the tie hes been signed by thoage 2 should be detached.	þ	Part II. Other significant conditions cont	ributing to death but not re	sulting in the un	derlying cause	given in Part I.			o the cause of death?
al Record		Completed						24a. Was an autopsy performs	prior to	utopsy findings available completion of cause of
Ĭ	Physician: this certific ral director,	o Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 No	spital:			Other.	eath Check only one		
on of	ding Phys h. After this funeral dir	-4	27. Manner of Death  12 Natural 5 Pending	28a. Date of Injury (Month, Day Year)	ER/Outpatient 28b. Time of Injury	28c. Ir	ijury at Vork?	Home 5 Resident		cify)
Division of Vital	or Atten	Certification;	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Spec	nome, farm, stre		Yes 2 No	28f. Location (Stre. City or Town,	et and Number or Ru State)	ural Route Number,
	To the Hospital within 24 hours a To the Funeral I completely filled	edicai	29a. Certifier Certifying Physic (Check only one)	cian: To the best of my kn if: On the basis of examin and manner stated.	owledge, death ation and/or inve	occurred at the estigation, in m	time, date and plac y opinion, death occ	e, and due to the cau- urred at the time, date	se(s) and manner as and place, and due	stated. to the cause(s)
)	To the within 2 To the complex		29b. Signature and title of certifier	ule			09110519		Date signed (Monte bruary 26	
- 1	4)		30. Name and address of person who com			rint)		ver Spring		
	Sta Registra		31. Date filed (Month, Day, Year)	2. Registrar's Sign	ature	8,	, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	· — vering	- <u> </u>	_

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 16 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year 27,2006 Joseph Adolph Mayr February 6:35 P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Crofton Convalescent Center Crofton Anne Arundel 6. Sex 11 M 2□ F If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) NOV. 1, 1915 9. Birthplace (State or Foreign Country) Mary Land Funeral Days Hours Months 90 Nov. 213-14-5201 Director Usual Residence of Decedent the Maryland **%poy** 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits traumatic event, the Medical Examiner must be notified at Director 1 ☐ Yes 2X No 28a-f Anne Arundel Davidsonville 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Itams 23a or 1289 Rossback Road 21035 USA death v 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 and 2 should be filed within 72 hours after Health and Mental Hygiene. sm 27 is marked other then "netural", or Ite Armed Forces: 1 □ Yes 2 □ No If Yes, Give Year or Dates:1 934 – 38 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 8 Service Manager Automobile 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Ledwina Greizel Joseph Anton Mayr 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2: Department of Health as Important: if itam 27 is any injury or othar trauonce. Dorothy A. Mayr / spouse 1289 Rossback Rd. Davidsonville, MD. 21035 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location · City or Town, State 1 ☐ Burial 2X Cremation 3 ☐ Removal from State ¹ 4 □ Donation 5 □ Other (Specify) Metropolitan Crematory 03/02/2006 Alexandria, VA. 21. Signature of Funeral Service Licens 22. Name and Address of Facility Beall Funeral Home 6512 NW Crain Hwy. Bowie, MD. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Aptie Sta Que to (or as a consequence of): Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, it any, learning to in mediate cause. Enter Underlying Cause (Disease or injury Examiner Dire to (or its a consequence of): The law requires that the death certificate be executed as the burial-transit that initiated events attending physician and for use as the burial-tran resulting in death) Last Due to (or as a consequence of): Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 23d. Date of delivery 3 Ectopic pregnancy Year Month Day 4☐Pregnant at time of death 5 Other (specify) signed by the 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? 1 Yes 2 No Division of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA Other: 4 virunsing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No r 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Certification: After To the Hospital or Attending 1 Matural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident Diractor: 6 Could not be determined 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \ Homicide hours after within 24 hours a To tha Funaral C 29a. Certifier 1 Socartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of th (Item 23a) (Type, Print)

State Registrar

31. Date filed (Month, Day, Year)

e1. 	La Morg	an	1 - For State State Registrar	of Maryland / Depa	artment of I			ene () () 6	07990					
	Physici /Medio		Decedent's Name (First, Middle, Last)     SHEILA MORGAN				2. Date of Death Month Februa		3. Time of Death 06 1:42 A M					
	Examir	er	4a. Fecility Name (If not institution, give street and n Southern Maryland Hospi  5. Social Security Number 6. Sex			ton If Under 24 Hrs.	8. Date of Birth	Prince Ge	orge's					
	Funeral Director		579-80-3430 1 M 20 F Usual Residence of Decedent	48 Yrs.	Months Days	Hours Min.	(Month, Day, Y JULY 13	1957 WA	hplace (State or Foreign unity) SH., D.C.					
	the Marylar 28a-f ehow cuffied at	ector	10a. State 10b. County  MD PRINCE GEOI  10e. Street and Number	10c. City, Town or Lo	E HILLS	}			10d. Inside City Limits 1 XYes 2 □ No					
	3a or	ğ	7206 TEMPLE HILL RD		20748			. Citizen of What Co JNITED S'	TATES					
036	within 72 hours after deeth with the Maryland ene. then "natural", or iteme 23a or 28a-f ehow ha Madical Examirar must be rollified at	by Funeral Director	Armed F	2⊠No live		Hispanic Origin? (Spe an, Mexican, Puerto I		14. Race - Ame Black, White Specify: WH	ncan Indian, e, etc.					
21215-0036	within 72 ho ene. then *natur he Medical	Completed	15. Decedent's Education (Specify only highest grade completed Elementary/Secondary (0-12) College 11th	) (Give	dent's Usual Occup kind of work done DO NOT use retire	during most of working	ng 16	b. Kind of Business/						
d 2	Hygin other	Be Co	17. Father's Name (First, Middle, Last)		• •	18. Mother's Name	(First, Middle, Ma	RESTAURI iden Sumame)	ANT					
Maryland	should be and Mental marked o	To B	STANLEY LAWRENCE PEA				B. NIC							
Baltimore, Ma	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylan Depertment of Health and Mental Hygiene. Important: If item 27 is marked other then "natural; or items 23a or 28a-f show with injury or other traumatic event, the Medical Examinat must be notified at anone.		19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, 2 SHIRLEY DIANA PEARSON-PARK SIS 4710 JEAN MARIE DR. FT. WASHI 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or cemetery, crematory or other place) 21. Signature of Funeral Service Louised 22. Name and Address of Facility 23a. Page Enter the disease or complications that caused the death. Page and Address with a surface of Address with a surface and Address with a surface of Address with											
	Physician /Medical Examiner portion and po	dicai Examiner	Sequentially list conditions. If any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	V VNOW	er the mode of dyin				Approximate Interval Between Onset and Death					
P.O. BOX 68	The law requires that the death certificate be executed to has been signed by the ettending physicien and bage 2 should be detached for use as the burial-transit	Physician/Medic	in the past 12 months?	nant at time of death 5	Ectopic pregnancy Other (specify)	,		23d. Date of deli Month	very Day Year					
rds, r	w requires that been signed b should be deta	þ	Part II. Other significant conditions contributing to	death but not resulting in the ur	nderlying cause giv	ren in Part I.			the cause of death?					
		Completed					24a. Was an autopsy performed	d? prior to death?	topsy findings available completion of cause of					
\ \ \ \ \	sician certifi irector	o Be	25. Was case referred to medical examiner?  1 X Yes 2 No Hospital: 1	Inpatient 2 ER/Outpatien	3 DOA Oth	26. Place of Death								
0	ding Phy h. After this funeral d	n: To	27. Manner of Death 28a. Date	Inpatient 2 A ER/Outpatien of Injury 28b. Time of Injury Injury	28c. Injur	4 🗆 Nulsing Hon	8d. Describe how	e 6 Other (Specinjury occurred	ofy)					
/ISIO	Attending Physician: It death. Sector: After this certified by the funeral director.	Certification:	2 Accident investigation 3 Suicide 6 Could not be		M 1 🗆	Yes 2,⊠No	SVBTEC 8f. Location (Street	T WAS	S VLOT					
á	pitel or Atl ours after d beral Direct filled in by		4 Milliomiciae build	Ing, etc. (Specify)  (PCNCE		-	7206 TEM	State) IPLE HILLS K	O, TEMAE HIUS					
	To the Hospitel or Attentwithin 24 hours after death To the Funeral Director: completely filled in by the	Medical	(Check only 27 Medical Examiner: On the I	pasis of examination and/or invener stated.	restigation, in my o	pinion, death occurre	d at the time, date	and place, and due  Date signed (Month	to the cause(s)					
	⊢ ≯ ⊢ ŏ		· aueI2				1							
2			30. Name and address of person who completed cau  AMA WWS (0, M.D.		Print)	Baltimore		ebraury 19 nd 21201	7, 4000					
3	Sta Registr	_	31. Date filed (Month, Day, Year)  MAR 0 1 2006	Registrar's Signature	W									

		1- State of Ma State of Ma		rtment of Health and I tificate of Death		ene 0 0 6	07991
Physi		Decedent's Name (First, Middle, Last)	Morris		2. Date of Death Month February		3. Time of Death 9:54 A. M
/Med Exam	iner	4a. Facility Name (If not institution, give street and number)  Washington Adventist Hosp  5. Social Security Number 6. Sex 7. Age	ital (In yrs. last birthday)	4b. City, Town, or Location of Death  Takoma Park  If Under 1 Year   If Under 24 Hrs.	)	4c. County of Dea	mery
Funera Directo		218-80-8816  Usual Residence of Decedent	83 Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day, January	8, Jan	nthplace (States Feign ountry) naica, Indies
e Maryland Sa-f show	Director	10a. State 10b. County  District of Columbia	10c. City, Town or Lo	cation hington			10d. Inside City Limits  1X Yes 2 □ No
with th	Die	10e. Street and Number  5824 - 7th Street, N. W.		10f. Zip Code <b>20011</b>		g. Citizen of What C nited Sta	•
Maryland 21215-0036 d 2 should be filed within 72 hours after death with the Maryland th and Mantal Hygene. 71s marked other than "natural", or Items 23a or 28a-f show traumatic event, the Madical Eventher must be rotified at	ted by Funeral	11. Marital Status  1 □ Never Married 2 Married 3 □ Widowed 4 □ Divorced  15. Decedent's Education	16a Deced	Vas Decedent of Hispanic Origin? (S Yes, specify Cuban, Mexican, Puert Yes 2 No Specify:	pecify Yes or No- o Rican, etc.)	14. Race - Am Black, Wh Specify:	erican Indian, ite, etc. Black
21215 d within 7 giene. orthen 'n	Completed	(Specify only highest grade completed)  Elementary/Secondary (0·12)  6th grade  College (1·4or 5+	)	kind of work done during most of wor DO NOT use retired) ndry Attendant	xing	Universi Home	ty Nursing
E 9 7 3	To Be C	17. Father's Name (First, Middle, Last)  Charles Robinson		18. Mother's Nam <b>Emily</b>	ne (First, Middle, Ma Mighty	aiden Sumame)	
73 ₹ ₹		Headley Alexander Morris (Hi Sonia May Morris (Daughter	usband) Mailin	g Address (Street and Number or Ru  - 7th Street, N.W.	ral Route Number, (	City or Town, State.	Zip Code) 20011
altimore, rmit. Pages 1 ar partment of Hea portant: If item;		20a. Method of Disposition  1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)		sition (Name of natory or other place) Feb. ashington Cemeter		oc. Location - City o	r Town, State
Baltimol permit. Pages Department of Important: If it any injury or or		21 Signature of Funeral Segrice Ucensee	ves R	Name and Address of Facility N. Horton Compa OO Kennedy Street	ny Mortic	cians, Inchington,	c. D.C. 20011
8760, sate be executed Wedica Examine hysician and the burial-transit	1	Sequentially list conditions. b	consequence of):	er the mode of dying, such as cardiac Matter How - Vasuu	Proceed Description	lest mones Ident	Approximate Interval Between Onset and Death
I Records, P.O. Box 6 The law requires that the death certific the has been signed by the attending page 2 should be detached for use as	Physician/Me	IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1 □ Yes 2 ▼ No 9 □ Unknown  23c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at ti	Fetal death 3	Ectopic pregnancy Other (specify)		23d. Date of de Month	blivery Day Year
rds, P.O. I quires that the de n signed by the a uld be detached f	þ	Part II. Other significant conditions contributing to death but	not resulting in the un	iderlying cause given in Part I.			o the cause of death?
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on of ding Phys After this funeral di	tion: To Be	25. Was case referred to merical examiner?  1  Yes 2 No Hospital: 1 Inpatient  27. Manner of Death 1 Natural 5 Pending 2 Accident investigation		Other	ome 5 Residen  28d. Describe how	ice 6 Other (Sp.	əcify)
DIVISIO al or Attendi after death. I Director: A d in by the ft	Certification:	2 ⊆ Suisido 6 ☐ Could not be	y - At home, farm, stre (Specify)	eet, factory, office	28f. Location (Stre City or Town,	eet and Number or F State)	Tural Route Number,
DIVISION To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	ledical C	29a. Certifier (Check only one)  Certifying Physicien: To the best of and manner state	xamination and/or inv	occurred at the time, date and place estigation, in my opinion, death occu	, and due to the cau rred at the time, dat	use(s) and manner a e and place, and du	s stated. e to the cause(s)
To the within To the comp	M	29b. Signature and the of certifier		29c. License number.	17	d. Date signed (Mon	th. Dey, Year)
		30. Name and addr ss of person who completed cause of dea				11	20912
S Regis	tate trar	31. Date filed (Month, Day, Year)  MAR 0 3 2006  State of the state of	s Signature	arroll Avenue;Sui	tte 205;Ta	akoma Par	k, Maryland

			1 - For State Registrer		ryland / Dep <i>Ce</i>		nt of Hea te of De		Mental H	ygiene Reg. No.	06	0 1992
п	Dhomini		1. Decedent's Name (First, Middle, L.	ast)					2. Date of D Month	eath Day	Vans	3. Time of Death
	Physici /Medio Examir	cal	Servando 4a. Facility Name (If not institution, gi	B.	Mama		Town, or Loc	ation of Death	February	27, 200	Year  6  Inty of Death	2:50 A M
	Examir	ier	9303 Sandy Creek Roa				Washing		•		ce Geor	
	Funeral Director		5. Social Security Number 6.		(In yrs. last birthday		r 1 Year   If (	Under 24 Hrs. ours Min.	8. Date of B	irth	9. Birth	place (State or Foreign untry) Lippines
	pu .		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or L	ocation						
	be filed within 72 hours after death with the Maryland nial Hygiene. ed other then "natural", or Iteme 23a or 28a-f ehow event. The Madical Examinar must be notified at	tor	Maryland Prince G		Ft. Washi							10d. Inside City Limits 1 Yes 2XXNo
	or 28a	Funeral Director	10e. Street and Number			10f. Zip	Code			10g. Citizen	of What Co	untry?
	23a c	alD	9303 Sandy Creek Ro	ad		į.	20744			USA		
	r dea	Iner	11. Marital Status	12. Was Decedent E Armed Forces?	ver in U.S. 13.	Was Dece	dent of Hispan cify Cuban, M	nic Origin? (Si exican, Puert	pecify Yes or N		Race - Amer Black, White	
36	rs afte	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 XYes 2 No If Yes, Give Year or Dates:		1 🗆 Yes		pecify:		Spe		lipino
21215-0036	2 hou	ed k	15. Decedent's E	ducation	16a, Dece	dent's Usu	al Occupation			16b. Kind of	f Business/l	ndustry
215	C *	Completed	(Specify only highest gr Elementary/Secondary (0-12)	College (1-4or 5-	(Give	kind of wo DO NOT u	ork done during se retired)	g most of wor	king			•
21	should be filed within a Mental Hygiene. Imarked other then imatic event. Its M	Con		4	Syste	ms Pro	grammer			Federal	Govern	ment
nd	tal Hy d oth	Be	17. Father's Name (First, Middle, Las	יו					ne (First, Middle		iame)	
₹	should be and Mental marked o umatic eve	2	Marcelo Maman						ana Buqui	<del></del>		
Maryland	s 1 and 2 should f Health and Mer Item 27 ie marke other traumatic		19a. Informant's Name/Relationship Myrna O. Maman / Wife	**					ra <i>l Route Numi</i> Vashingto			
	of Heal item 2 other		20a. Method of Disposition	<del></del>	20b. Place of Disp cemetery, cre			ad It. V	Date	20c. Locatio		
Baltimore,	00		1XXBurial 2 ☐ Cremation 3 [ 4 ☐ Donation 5 ☐ Other (Speci		Resurrect			3//	/2006			aryland
E E	구두문문		21. Signal re of Funeral Service Lice						eorge P.			
ä	Depariment of the part of the		Dan P. K	Med					orge 1. Oxon Hill			0745
			23a Part 1. Enter the disease, or con shock, or heart failure. List only	pplications that caused to	he death. Do not en							Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	N	etesta	ter	lun	90	-~ ~			Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a	consequence of):		/					WINGS D
	± Xammer		Sequentially liet nonditions,	b								
	led nsit	Examiner	Sequentially liet conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequence of):							
	xecul al-trar	xan	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a	consequence of):						-	
8760,	death certificate be executed a ettending physicien and id for use as the burial-transit	calE		d								
9	g phy as the	edic	· · · · · · · · · · · · · · · · · · ·									
Вох	h certific ending p r use as	N/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of		∃Ectopic pr	2000000			23d. [	Date of deliv	very
-	s death ha etter ed for u	Physician/Med	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐ Pregnant at ti		Other (sp				P	Month	Day Year
P.0	that the de ed by the detached	Phy	9 Unknown					_				
	es De	by	Part II. Other significant conditions	contributing to death but	not resulting in the u	inderlying c	ause given in	Part I.		tobacco use co Yes 2 □ No		the cause of death?
Ö	w requir been s should	etec	- John O can	to .		_			-			
Records,	has l	Completed	MADONA	nerula					24a. Was			opsy findings available ompletion of cause of
<u></u>		o Co	25. Was case referred to medical	E-77.5					1 Yes	XX No	1 Yes	2 No
Vital	Physicien: this certific ral director,	To Be	examiner?	Hospital:	t 2 ☐ ER/Outpatie	at 2 C DC	Other		h (Check only			
0	g Phy er this eral c		27. Manner of Death	28a. Date of Injury	28b. Time o		8c. Injury at Work?	☐ Nursing H	28d Describe	how injury occ		ity)
jo	Attending F r death. ector: After by the funer	atlo	1 Natural 5 Pending 2 Accident investigation	( <i>Month, Day</i> n	Ye <i>ar)</i> Injury	м	Work? 1 ☐ Yes	2 🗆 No				
Division	or Atte	Certification:	3 Suicide 6 Could not be determined		y - At home, farm, st	reet, factory	, office		28f. Location	(Street and Nur wn, State)	nber or Rui	ral Route Number,
	ospital o hours afl uneral Di ly filled ir									M'		
	1 4 TT 0	Medical	29a. Certifier 1 Certifying Pl (Check only 2 Medical Example)	nysician: To the best of miner: On the basis of e	examination and/or in	h occurred vestigation	at the time, da , in my opinion	ate and place, n, death occur	and due to the red at the time,	cause(s) and date and place	manner as s	stated. to the cause(s)
	within 2 To the Complet	Mec	29b. Signature and Mile of contribing	and manner state	90.	290	. License num	nber		29d. Date sign	ned (Month	Day Year)
	110		blatch	1			COU	1-4				
*	16/		30. Name and address of person who	Smpleted cause of dea	ath (Item 23a) (Type	Print)	Arastoo	J ( Yazdani	MD	1-000	777	27,06
	90		9801 Creothi	tue zull	Silve		217	102	0902			
	Sta	- 1	31. Date filed (Month, Day, Year)	32. Registrar	's Signature	•	3					
	Registr	ar	FEB 2 8 2006	alux de	Market !							

			1 - For State Registrer	State of		nd / Depa		t of H	lealth a	and M			006	0799	3
			1. Decedent's Name (First, Middle,	Last)							2. Date of De		Van	3. Time of De	ath
	Physici		PRESTON	L.		MATTH	IEWS				Feb.	24.	2006		ΔM
	/Medic Examir		4a. Facility Name (If not institution, g	give street and nur	nber)			Town, or	Location of	of Death	100.		County of Dea	ath	77
	LAGIIII	161	29966 Ronald	Drive			Mec	han	icsv	1116	2	S	t Mar	ys	
	Funeral				7. Age (In yrs	. last birthday)		1 Year		24 Hrs.	9 Date of Bir	+h	0.8	rthplace (State or F	oreian
	Funeral Director		578-22-4698	1 <b>⊠</b> M 2□F	82	Yrs.	Months	Days	Hours	Min.	Aug. 9	192	3 Ma	ryland	o. o.g
L.			Usual Residence of Decedent				1							-7	
	/land		10a. State 10b. County		10c. C	ity, Town or Lo	ocation							10d. Inside City L	_imits
	Man	Ö	MD St.	Marys		Mechai	nics	7i 1 1	6					1 <b>⊈</b> ¥es 2	□No
	289 Land	Je C	10e. Street and Number				10f. Zip					10a. Citiz	en of What C	Country?	
	within 72 hours after death with the Maryland ene. than "naturei", or iteme 23e or 28e-f show ite Maulical Examinar musi be mailling at	Completed by Funeral Director	29966 Ronal	d Drive					659			-	S.A.	,	
	e 23	era		12. Was Dece		IS 13	Was Docor			ain? (Sne	oify Vac or No			erican Indian.	
	lten Iten	S	11. Marital Status 1 □ Never Married 212 Married	Armed Ea	rces? 2 □ No 19	43-	If Yes, spec	rfy Cuba	n, Mexican	, Puerto	cify Yes or No Rican, etc.)		Black, Wh	ite, etc.	
9	rs af	Ş.	3 ☐ Widowed 4 ☐ Divorced	If Yes, Giv Year or Da	9	. –	1 ☐ Yes	2XNo	Specify:				Specify: B	lack	
21215-0036	hou	pa	15. Decedent's		ates: 19		dent's Usua	al Occupa	ation		_	16h Kin	d of Busines:	- Anduste	
5	n 72	et	(Specify only highest	grade completed)		(Give	kind of wor	rk don <i>e</i> d	furina most	t of worki	ng	TOD. KIN	0 01 00311103	sindustry	
72	withi Bne.	Ĕ	Elementary/Secondary (0-12)	College (1	-4or 5+)		duce			•		Gro	ocery	Store	
2	iiled Hygi ther int,		17. Father's Name (First, Middle, La	est)		1100	auce	1101			(First, Middle	Maiden S	Sumame)		
au	ntal d o	Be											,		
Ë	d Me d Me nark natio	은	George Ma			105 14-15-		(0)	Mar	УE	llisor	1	T C1-1-	7:- 0 - 1-1	
<u>a</u>	12 st		19a. Informant's Name/Relationship		_									, ,	
ď.	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heelth and Mental Hygiene. Important: if item 27 is marked other than "naturei", or iteme 23a or 28e-f show minoraint: if item 27 is marked other than "naturei", or iteme 23a or 28e-f show any injury openitor and the notified at once.		Mary E. Matth  20a, Method of Disposition	<u>ews- Wi</u>		2996( Place of Dispo	6 Ror	nald	Dr	Mec.	hanics	svil.	Le Mi	D 20659 r Town, State	
5	S = 3		1 Burial 2 Cremation 3	☐Removal from 5	State	cemetery, crei	matory or o	ther place		_			•		
Baltimore, Maryland	Pa men		4 Donation 5 Other (Spe		/ G	ood Ho			,		2006			pring, N	
<u></u>	Depart Import any in		21. Signature of Funeral Service Lie	ensee /	/									ome, P.	
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	Physician		23a. Part 1. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final							cardiac o	r respiratory a	rrest,		Approximate Interval Betwee Onset and Dea	an ith
	/Medical		disease or condition resulting in death)		TE RE	SPIRTO	JRY E	ALL	URE						
	Examiner					MPHYSI	TM7								
		er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events		or as a consec		ייייי								
	be executed sicien and burial-transit	Examiner	Cause (Disease or injury that initiated events												
c.	exection and ital-tr	Exa	resulting in death) Last	Due to (	or as a consec	quence of):									
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68	fficat g phy as th														
č	ndin use	2	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, out								23	d. Date of de	livery	
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<u> </u>	that led b	by Physician/Med	Part II. Other significant conditions	s contributing to de	ath but not res	sulting in the u	nderlying ca	ause give	n in Part I.		23e. Did t	obacco us	e contribute t	o the cause of deat	h?
g	The law requires that the death certifica lie has been signed by the attending ph page 2 should be detached for use as th		Hyperte	nsion							10	Yes 2□	No 3□P	robably 4 🛣 Unki	nown
ក្ត	w require been significant	Completed									24a. Was	an	24h Wara a	utopsy findings ava	ulable
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<u>a</u>											1□ Yes	2 🔼 No	1 🗆 Ye	s 280 No	
\ <u>\</u>	Attending Physicien: r death. ector: After this certific by the funeral director, i	Be	25. Was case referred to medical examiner?	Hospital:				Othe	~		(Check only o				
<del>o</del>	Phys this aldi	2	1 Yes 2 No 27. Manner of Death	1		28b. Time of		^	4 🗀 Nui		ne 5 XResi			ecify)	
5	ding Ph h. After thi funeral	lo l	1 ☐ Satural 5 ☐ Pending	(Monti	n, Day Year)	Injury		8c. Injury Work			8d. Describe I	now injury	occurred		
S	r Attender death rector:	cat	2 ☐ Accident investigat 3 ☐ Suicide 6 ☐ Could not	he			М		es 2□N		10( 1	G:			
Division of Vital Records,		Certification;	4 Homicide determine	286. Place	of Injury - At n ig, etc. (Speci	ome, farm, str fy)	eet, factory	, office		2	City or To	vn, State)	Number or H	lural Route Number,	
_	Hospitai 24 hours a Funarai ( fuly filled		29a. Certifier 1 **Certifying	Dhyaio' T	hant of a little	audad - · · · ·		- 11	- 4 .	1 -1	- 4 4				
	To the Hospital or within 24 hours after to the Funaral Dir completely filled in	Medicai	(Check only 2 Medical Ex	Physicien: To the aminer: On the ba and mann	sis of examina	ation and/or inv	occurred a vestigation,	at the tim in my op	e, date and inion, deat	d place, a h occurre	nd due to the ed at the time,	cause(s) a date and p	nd manner a lace, and du	s stated. e to the cause(s)	
	To the within 2. To the Complet	Me	29b. Signature and title of certifier	und maill	5.0160.		29c	License	number			29d. Date	signed (Mon	th, Dey, Year)	
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	ID		Show	-Ma				VIO	101/6	)		C.,	K1'0	6	
	(		30. Name and address of person wh				,								
			Dr. Suresh G 31. Date filed (Month, Day, Year)	upta, M	D 47 egistrar's Signa	01 Rar	dolp	h_R	d Ro	ckv:	ille,	MD_	2085	52	
	Sta Registr	-	MAD A 1	2006	giotian a Gigili	A A		6.5							
	9.00		HILAIV O T		- S-										

			For State Registrar	State o	f Marylaı				lealth and Death	Mental Hy	/giene	UUU	0/5	194
	Dhysisi		1. Decedent's Name (First, Middle,	, Last)	-					2. Date of D Month	eath Day	y Year	3. Time	of Death
	Physici /Medic Examin	cal	EDWARD J. MCMAN  4a. Facility Name (If not institution,		mber)		4b. City,	Town, o	r Location of Dea	FEBRUAR	Y 24,	2006 County of Dea	8:55	Р М
	Lxaiiii		SUBURBAN HOSPITAL				BETH	ESDA			MC	ONTGOMERY		
	Funeral		,	6. Sex 1 🖾 M 2 🗆 F	7. Age (In yrs.		If Under Months	1 Year Days	If Under 24 Hr Hours Mir	. (Month, D	rth ay, Year)	9. Biri	hplace (State nuntry)	or Foreign
	Director		187-12-5736 Usual Residence of Decedent		83	115.				MAY 3,	1922	PENN	SYLVANIA	<u> </u>
	laryland show		10a. State 10b. County		10c. C	ity, Town or Lo	ocation						10d. Inside (	- ,
	the Maryla 28e-1 shov	ctor	MARYLAND MONTGOME	RY	ROCK	VILLE							1 □ Ye	s 2∭ No
	vith th	Funeral Director	10e. Street and Number				10f. Zip	Code			10g. Cit	izen of What Co	ountry?	
	eath w	eral	512 SADDLE RIDGE LA 11. Marital Status		edent Ever in U	J.S. 13.		9850 dent of H	lispanic Origin? (	Specify Yes or N	0-	U.S.A. 14. Race - Ame	nican Indian.	
(0	ours after death with ral", or Items 23e or Express recombility	Fun	1 ☐ Never Married 2 ☐ Marrie	Armed Fo	rces? 2 🗌 No					Specify Yes or N rto Rican, etc.)		Black, Whit	e, etc.	
903	hours a	d by	3 XWidowed 4 ☐ Divorced	If Yes, Giv Year or D	ates: WWI	I	1 Yes	211 No	Specify:			Specify: WH	ITE	
21215-0036	within 72 ho lene. r than "netur the Wedical	Completed by	15. Decedent' (Specify only highest	s Education grade completed)		16a. Dece (Give	dent's Usua kind of wo DO NOT us	rk done	during most of we	orking	16b. K	ind of Business	Industry	
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<u>ylar</u>	Menta Menta arked	To E	ANTHONY	MCMANAMON	·				KATHERINE			GALLAGI	IER	
Maryland	es 1 and 2 should be fi of Health and Mental H if item 27 is marked of or other traumatic ever		19a. Informant's Name/Relationsh			1				lurai Route Numi		r Town, State, 2	Zip Code)	
	1 and Health em 27		PATRICK J. MCMANAMO  20a. Method of Disposition	N/SON	20b.	Place of Dispo	sition (Nar	ne of		TON, VT Of Date		ocation - City or	Town, State	
آو	age straight		1 ABurial 2 ☐ Cremation  4 ☐ Donation 5 ☐ Other (Sp		State	сөтөтөгү, сгөг	matory or o	ther plac		20.12000		,		ND
Baltimore,	permit. Pages 1 Department of H Important: If ite any injury or oth	П	21. Signature of Funeral Service L		GAL	TE OF HE	2. Name an	d Addre	ss of Facility	02/2006		ER SPRING	MARYLA	MD
ä	Per Constitution of the Co		* (Imande	a Kuc	dewo					HOME, INC. ENUE, SILV		RING, MAR	YLAND 20	0904
			23a. Part1. Enter the disease, or o shock, or heart failure. List of	complications that combine cause on e	aused the dea	h. Do not ent	er the mod	e of dyin	g, such as cardia	c or respiratory	arrest,		Approxima Interval Be Onset and	etween
	Pnysician /Medical	9 0	Immediate Cause (Final disease or condition resulting in death)	a	AS		DON	1	NEUMI	NIA			3 WE	FKS
	Examiner			Due to (	or as a consec	quence of):								
1	THE NAME OF STREET	Jer	Sequentially list conditions, if any, leading to immediate cause. Energy upon my	b. Due to (	or as a consec	quence of):								
, D	xecuted and Il-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	С.										
1 d d	be egician ician buria	Ical Ex	resulting in death) Last	Due to (	or as a consec	quence of):								
2.h	ficate physis the			d										
% ×	ith certifik tending p	m/m	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, out	come of pregn		Ectopic pr	eanancy	,			23d. Date of del	-	
2/4 D. B	The law requires that the death certificate atte has been signed by the attending physbage 2 should be detached for use as the	by Physiclan/Med	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		ant at time of		Other (sp					Month	Day	Year
NEG	that the	/ Ph	Part II. Other significant condition	ns contributing to de	ath but not res	sulting in the u	nderlying c	ause givi	en in Part I.	23e. Did	tobacco u	se contribute to	the cause of	death?
- O.sp.	quires in sign		SEPS15							10	Yes 2[	□No 3□Pr	obably 4	Onknown
<000	law requii as been s 2 should	Completed								24a. Was		24b. Were au	topsy findings	available
N N		Сош									ormed? No	death? 1 ☐ Yes	·	
Z ON SET	sician: certific rector,	Be	25. Was case referred to medical examiner?	Hospital:	,			. Oth	00	ath (Check only				
4	Phys this ral di	5:1	1 Yes 2 No 27. Manper of Leath	28a. ate o	of Injury	ER/Outpatien 28b. Time of		8c. Injury Work	4 🗀 ivursing i	Home 5 Res 28d. Describe			city)	_
2/VE	nding l ath. r: After e funer	atlor	1 Natural 5 ☐ Pending 2 ☐ Accident investiga		h, Day Year)	Injury	М		k? Yes 2 □ No					
Z SIS	or Attendater death	Certification:	3 Suicide 6 Could no 4 Homicide determine	and Zoe. Place	of Injury - At h		eet, factory	, office		28f. Location ( City or To		d Number or Ru	ral Route Nur	n <i>ber</i> ,
7.60	ospital or hours afte uneral Dir ily filled in	Cer												
Z	24 E	edical	29a. Certifier (Check only one)  Certifying 2 Medical E	Physician: To the examiner: On the ba and mann	asis of examina	owiedge, death ation and/or in	occurred vestigation,	at the tim in my op	ne, date and plac pinion, death occ	e, and due to the urred at the time,	date and	and manner as place, and due	stated. to the cause(	s)
1	To the within 2 To the comple	Me	29b. Signature and title of certifier						number		29d. Dat	e signed (Monti	n, Day, Year)	
			Motorfry	whi			1	1-2.	3308		FE	B, 25	, 2006	5
	4		30. Name and address of per In w		e of death (Iter	m 23a) (Туре, РО RCCI	Print)	6E	DR.#9	1100 BE	אורבי	COA MI	12081	7
	Sta Registr		31. Date filed (Month, Day, Year)	2006	egistrar's Signa	ature A	golf)							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene UD 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** FEBRUARY 2700 MADDOX /Medical 4a Facility Name (If not institution, give street and nu PEPA NAME OF THE NAME 4c. County of Death 4b. City. Town, or Location of Death Examiner MOUNT AIR AR 8. Date of Birth (Month, Day, Y Feb. 26 Birthplace (State or Foreign Country) **Funeral** Days Hours 1**X**M 2□F 213-12-1663 Yrs Maryland Director Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits 28e-f show or other treumetic event, the Medical Examiner must be notified at Md. Montgomery Silver Spring 1 ☐ Yes 2 No Directo 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 15311 Beaverbrook Court 20906 United States or Items 23a 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠ Yes 2 □ No If Yes, Give Year or Dates: WWII Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2K Married 1 ☐ Yes 2 No Specify: ۵ WWII 3 ☐ Widowed 4 ☐ Divorced White "naturei", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7;
Department of Health and Mental Hygiene.
Important: if item 27 is marked other then "ns any nijury or other treumetic event, if ite Mental pance. (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Surveyor Land Surveyor 10 0 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Charles J. Maddox Eleanor Μ. Mahonev 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cornelia F. Maddox / Wife 15311 Beaverbrook Court, Silver Spring, Md. 20906 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Metropolitan Crem. 2/28/06 Alexandria, Va. \* 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Muriel H. Barber Funeral Home 21. Signature of Funeral Service Licenses Box 5038, Laytonsville, Md. 20882 23a. Partí. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician BRONCHOPNEUMONIA Lock disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner SENILE DEMENTIA Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine use as the burial-transit resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4 Pregnant at time of death 5 Other (specify) the þ signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ YVERTENSION 1 Yes 2 No 3 Probably 4 Unknown Completed DISTATE 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an arthritis Ostes -2 No 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No

Box 68760 law requires that the death certificate be P.O. 1 Division of Vital Records, The Hospital or Attending Physicien: this After death. Director:

Baltimore, Maryland 21215-0036

Certification:

24 hours after of Funerei Direc within 2 To the To the

27. Manner of Death 1 Natural 5 Pending

2 Accident 3 Suicide 4 - Homicide

investigation 6 Could not be determined

28a. Date of Injury (Month, Day Year)

and manner stated.

28b. Time of Injury

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

🔟 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number

Parkeray

D. 3046

D- 308

28c. Injury at Work?

29d. Date signed (Month, Day, Year) 28/ 2006

Columbia, MD. 2145

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

N. B. VELLANZ, 8850, Columnia, 100 N. B-VELLANKI

3. Registrar's Signature

31. Date filed (Month, Day, Year) 0 1 2006

29a, Certifier

(Check only one)

Registrar

+

			For Stete Registrar	S	tate of	Marylan	•	artmen rtificat			and M		Reg. No.	006	0	179	97
		松	Decedent's Name (First, Middle, Last)  2 Date of Death Month Da								ath Day	Ye		3. Time of	Death		
	Physici /Medic		Touce Marie Nelson						March	06		06	5:30	A <sup>M</sup>			
r	Examir		4a. Facility Name (If not institution, give street and number)					4b. City,	Town, or	Location o	of Death		4c.	County of D	eath		
			St. Mary's Hospital				Leon	ardt	own			5	St. Ma	ry's	3		
	Funeral		5. Social Security Number	6. Sex	7.	Age (In yrs.	last birthday)	If Under Months	1 Year Days	If Under:	24 Hrs. Min.	8. Date of Bir (Month, Da	th v. Year)	9.	Birthplac	ce (State o	or Foreign
	Director		212-74-2390	1 L M	2X F	4	9 Yrs.	Nontrio	Days			Sept 25		6 M		Ĺand	
	2		Usual Residence of Decedent			10a Cit	n. Taum and								100	l Incide C	in a limite
	inylar phow	_	10a. State 10b. Count	у		100. CII	y, Town or Lo	ocation							100	I. Inside C	X□ No
	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. and Mental Hygiene. is marked other then "naturel", or items 23s or 28e-f show eumatic event, the Medical Examiner mant be notified at	cto	Maryland St. N	<u>lary's</u>			Mec	hanic		1e							
		Director	10e. Street and Number					10f. Zip					10g. Citi:	zen of What		y?	
		rai	26400 Laurel					20659						USA			
	ag ag	Funeral	11. Maritaf Status		Armed Forc		.S. 13.	Was Deced If Yes, spec	dent of Hi cify Cuba	spanic Ori n, Mexican	gin? (Spo , Puerto	ecify Yes or No Rican, etc.)	)-	<ol> <li>Race - American Indian, Bfack, White, etc.</li> </ol>			
စ္က	or it		1 Never Married 2 Ma	200				1 🗆 Yes	2 <b>X</b> No	Specify:			Specify: B1:				
21215-0036	ural',	d by	3 Widowed 4 Divorce		Year or Dates:								16b. Kind of Business				
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2	within 72 liene. then "nat	m d	Elementary/Secondary (0-12)		College (1-4or 5+)			DO NOT use retired)				Mainter			000		
7	Hygie other i		12 Custodian  17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Last)									nce					
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Ĕ	should the condition of	2	Joseph Aloys:				10h Maili	ng Addross	/Stroot	-		al Route Numb			a Zin C	'odol	
Maryland	nd 2 st lith and 27 ie n r treun		(2)		-												.0
	1 and Healt In 2 Ther		Linda Short	Daug	20b. Place of Dispo			O Laurel Grove Road								<i>J</i>	
ō	permit. Pages I and 2 should Department of Health and Men Important: If item 27 ie marke eny injury or other treumatic pages.		1 N Burial 2 ☐ Cremation		oval from St	ale				1				Len, M		,	
altimore,	t. Pag tment tant: I tjury o		4 Donation 5 Other			Que	en of Pe					2006	IIE I	en, n	ע	_	
Ba	Depar Depar Impor		21. Signature of Funeral Service	Licensee	M	. (	) 2	2. Name ar Mat				Funeral	Home	, P.A.			
	40 = 9 Q		23a. Part1. Enter the disease	even S	Hana	iner	-					ardtown,		650		Approxima	10
ox 68760,	hysician /Medical xaminer	ilner	shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, and the sequentially list conditions, cause. Enter Underlying Cause (Disease or injury	a	Pner Due to (o			<u> </u>								nterval Bei	
		Physician/Medical Examin	d												Year		
о. В	e de the a	/sic	1 ☐ Yes 2 DXNo 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown														
ds, P.(	The law requires thet the de ste has been signed by the a page 2 should be detached f	ď	Part II. Other significant containous continuously to dealing in the underlying cause given in 7 at 1.										cause of o				
Record	w requir been si should	Completed	24a. Was an									24b. Were autopsy findings available			available		
ĕ	has has	gu										auto		prior deat	to comp	oletion of o	cause of
<u>~</u>		ပ္ပိ										2 <b>X</b> No	10	res 2	□ No		
<b>E</b>	Physician: The lav this certificete has al director, page 2	Be	25. Was case referred to medic examiner?		26. Place of Death (Check only one)												
5	hysi this o	မ	1.XXes 2 No								sing Home 5 ☐ Residence 6 ☐ Other (Specify)						
_	ding P	ë	27. Manner of Death 1 Naturaf 5 ☐ Pend	ing	28a. Date of Injury 28b. Time of (Month, Day Year) Injury			Work?				28d. Describe how injury occurred					
É	or Attendent Ifter deatl Director: in by the	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 6 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and City or Town, State)								nd Number or Rural Route Number, e)						
	To the Hospital within 24 hours a To the Funeral I completely filled	Medicai C	29a. Certifier (Check only one)  1 Certify 2X Medica	ing Physici Il Examiner	an: To the b : On the bas and manne	is of examina	owledge, deat ation and/or in	th occurred evestigation	at the tim	ne, date an pinion, dea	d place, th occur	and due to the red at the time,	cause(s) date and	and manne place, and	r as stat due to ti	ted. he cause(	s)
	To the within 2 To the complet	M	29b. Signature and the o certif	fr /		Ma		29c. License number 29d.					29d. Dat	Date signed (Month, Day, Year)			
			XXX	1	( ) OCA					OCME Mar			ch 7	2.00	6		
			30. Name and address of person	n who comp	eleted cause	of death (Ite	n 23a) (Type,	Print)		, <b>CIL</b>			March 7, 2006				
			5. R. t	101-	AV	~			L1 P€	enn St	tree	t Balt	imor	e, Mar	:y1a	nd 21	L201
14 ×	Sta Regist		31. Date fifed (Month, Day, Yea	,, 8 2006		gistrar's Sign		and a	1								

		•	For State Registrar	State of Maryla	nd / Dep	artmen	nt of Health and the of Death	Mental Hygie	_	7998		
· ·	æ.		Decedent's Name (First, Middle, Las	t)			2. Date of Death		3. Time of Death			
4,65	Physici	49	Margaret Elizabeth North					Feb. 28,	<sup>Day</sup> 2006 Year	10:55 p м		
13	/Medic Examin		4a. Facility Name (If not institution, give street and number) Chesapeake Woods Center				Town, or Location of Dear Cambridge	4c. County of Death Dorchester				
Sept.	Funeral Director		5. Social Security Number 6. Social Security Number 1. Social Security	TH 2576	s. last birthday, 7 Yrs.	Months			9. Birthe Cour 1919 Mary	place (State or Foreign htry) Land		
5	death with the Maryland me 23s or 28s-f show	tor	10a. State 10b. County  Maryland Dorche		City, Town or L		oridge		1	0d. Inside City Limits 1 ☐ ¥6s 2 ☐ No		
Z	3s or 28s	al Dire	10e. Street and Number 410 Kent Stree	t		10f. Zip	21613	10g	j. Citizen of What Cour USA	,		
	72 hours after deat natural, or items 2 dical Exponent inte	Completed by Funeral Director	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	U.S. 13.		dent of Hispanic Origin? (Scify Cuban, Mexican, Puer 2 Specify:	Specify Yes or No- to Rican, etc.)	14. Race - Americ Black, White, Specify: Whi	etc.		
Maryland 21215-0036	iled within Hygiene. ther than " nt, the Me	mpleted	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  Crab Picker						Shellfish	,		
and 2		Be	17. Father's Name (First, Middle, Last)  Samuel Parks						(First, Middle, Maiden Sumame) y Robinson			
<u>Z</u>	should be that Mental I	6	19a. Informant's Name/Relationship (7	уре, Print)	19b. Maili	ing Address			GOLL City or Town, State, Zip Code)			
S	lith an 27 le r		Mr. Johnnie G. No:	rth/Spouse	525	Glent	ourn Ave., C	ambride.	MD 21613			
re,	of Heir		20a. Method of Disposition	20b	. Place of Disponentery, cre	osition (Nai	me of other place)		c. Location - City or To	wn, State		
Ë	Pages nent of int: If It iry or o		1 ☐ Surial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify					/03/2006 C	Cambridge,	MD		
Baltimore,	Departin Imports any in L	K	4 Donation 5 Dother (Specify) DorchesterMemorialPark 03/03/2006 Cambridge, MD  22. Name and Address of Facility Curran—Bromwell Funeral Hone, P.A. 308 High St., Cambridge, MD 21613									
	Physician /Medical		t,	Approximate Interval Between Onset and Death								
760,	e be executed /sicien and e burial-transit	icai Examiner	Sequentially list conditions, and the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		0 years							
P.O. Box 68	The law requires that the death certificat ate has been signed by the attending phy page 2 should be detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome of preg 1 □ Live birth 2 □ Fr 4 □ Pregnant at time o 9 □ Unknown	etal death 3	□Ectopic p □ Other (sp		23d. Date of delive	id. Date of delivery Month Day Year			
	uires that signed by								e. Did tobacco use contribute to the cause of death?  1  Yes 2 No 3 Probably 4 Unknown			
Records,	fhe law requir le has been si age 2 should l	Completed by						24b. Were autopsy findings available prior to completion of cause of death?				
ita	ilan: artifica ctor.	Be C	25. Was case referred to medical examiner?				26. Place of De	ath (Check only one)				
Division of Vital	To the Hospital or Attending Physiclan: The lav within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	2	1 Pes 2 No  27 Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day Year)  28b. Time of Injury M  28c. Injury at Work? 1 Yes			JA 4 Nursing	Home 5 Residen	nce 6 Other (Specify) w injury occurred			
Divisi	To the Hospital or Attending I within 24 hours after death.  To the Funeral Director: After completely filled in by the funer	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined					28f. Location (Stre City or Town,	al Route Number,			
	ne Hospit n 24 hour ne Funera	Medical (	29a. Certifier (Check only one)	e, and due to the cau	and due to the cause(s) and manner as stated. rred at the time, date and place, and due to the cause(s)							
	To the within To the comp	Ž	29b. Signature and title of certifier				c. License number	d. Date signed (Month, Day, Year)				
			Madrie	n do			14005997	3	3/1/06			
_			30. Name and address of person who	100 Bramble	e Str	eet,	HOOS997	ge, Mi	2161	3		
	Sta Regist		31. Date filed (Month, Day, Year)	2006 32. Registrar's Sig	nature	Someth.						

			For State Registrar	State of Maryla		artment of rtificate of				giene Reg. No.	06	07999	
		_2%	Decedent's Name (First, Middle, Last)  2. Date of Death Month  Month										
	Physici		Ray Jeffers	on Nessel	rođt				03	OS A	2006	22:40 M	
Es.	/Medic Examin		4a. Facility Name (If not institution, give			4b. City, Town,	, or Location	of Death		4c. Cour	nty of Death	1	
		90 14 (3)	SAMPIN HIPAI	OT HOSPIT	Al	(JIMA	1-20LA	MIN		FIL	11-6A	1)4	
	Funeral		5. Social Security Number 6. Se		. last birthday)	If Under 1 Yea			8. Date of Bird	th Voarl	9. Birth	oplace (State or Foreign untry)	
	Director		234-52-8411	× 2 F 74	Yrs.	Months Day	s Hours		(Month, Da J <b>an</b> 6			Virginia	
	D		Usual Residence of Decedent										
	rylar ihow	L	10a. State 10b. County	10c. C	ity, Town or Lo	ocation						10d. Inside City Limits	
	be filed within 72 hours after death with the Maryland all Hygiene. Id lithylighen "netural", or items 23a or 28s-f show other then "netural", or items 23a or 28s-f show event, the Mudical Examerant from Indilled at	cto	WV Gr	int		Mount	Storm	<u> </u>				1 ☐ Yes 2 🛣 No	
		ire	10e. Street and Number			10f. Zip Code	•			10g. Citizen o	of What Cou	antry?	
		Funeral Director	HC 76 Box 728				267	39			USA		
	dea dea	ne	11. Marital Status	12. Was Decedent Ever in Armed Forces?	U.S. 13.	Was Decedent of If Yes, specify Cu	f Hispanic O	rigin? (Specan, Puerto R	ify Yes or No ican, etc.)	- 14. R	lace - Amer lack, White	ican Indian, . etc.	
9	after or It		1 Never Married 25 Married	1 XYes 2 No		1 ☐ Yes 21X N				Spec		/hite	
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5	72 t	Completed	15. Decedent's Ed (Specify only highest grad		(Give	dent's Usual Occ kind of work don	e during mo	st of working	g	16b. Kind of		•	
21	ithin he n	g	Elementary/Secondary (0-12)	College (1-4or 5+)		DO NOT use reti		d Mech		Heavy			
2	filed withi Hygiene. Ather ther		12th 17. Father's Name (First, Middle, Last)		Heavy	Equipme				Maiden Sum		Service	
Maryland	ag ta b	To Be		esselrodt				omi	(1 It's), WIIOOIO,		Berg		
7	s 1 and 2 should in Health and Men Itam 27 ie marke other treumatic	-	19a. Informant's Name/Relationship (7	ype, Print)	19b. Maili	ng Address (Stre	et and Numi	ber or Rural	Route Numbe	er, City or Tow	m, State, Z	ip Code)	
	5 de 2 d		Delores Nesselrod	lt/wife	HC	76 Box 7	28, M	ount S	Storm,	WV 267	39		
Baltimore,	t Head Itam		20a. Method of Disposition		Place of Dispo	osition (Name of matory or other p	lace)	Da	ite	20c. Location	n - City or T	Town, State	
9	Pages nent of I int: if its ury or o		1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify			rove Cen		3/9/	/06	Mount	Storm	a. WV	
量			21. Signature of Funeral Service Lices	1 2 4		2. Name and Add				32 S. S			
Ba	permit. Departr Importa eny inju		Right	Track	S	tewart H	unera	1 Home				21550	
	Physician /Medical Examiner		23a. Part1. Enter the disease, or comp	dications that caused the dea							,	Approximate	
			shock, or heart failure. List only of Immediate Cause (Final				s0 C	2 4 4 1 1	0			Interval Between Onset and Death	
			disease or condition resulting in death)	a. NOUSNAC	C CCI	e au	16- 6	***	00 K				
0.0		ii		Dae to (or as a conse	quonce on.								
		P.	Sequentially list conditions										
		ij	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury										
	xecu and	Examiner	that initiated events resulting in death) Last	c Due to (or as a conse	quence of):								
8760	death certificate be executed e attending physicien and at for use as the burial-transit			4									
687	physi s the b	dicai		0									
	eath certific attending p	Physician/Me	IF FEMALE:	23c. If yes, outcome of pregr	nancy					23d [	Date of deliv	verv	
Вох	atter for u	iar	23b. Was decedent pregnant in the past 12 months?	1☐Live birth 2☐Fel 4☐Pregnant at time of		Ectopic pregnant Other (specify)	тсу				Month	Day Year	
o.	the dr	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown									
Δ.	that the de led by the a detached		Part II. Other significant conditions co	given in Part	tl.	23e. Did to	bbacco use contribute to the cause of death?						
ds,	eg pe	d by							101	res 2□No	3 ☐ Pro	bably Winknown	
of Vital Record	w requir been s should	Completed							24. 145.	244	144		
ec	has t	idu							24a. Was autop		prior to co death?	opsy findings available ompletion of cause of	
=		ပိ							1 Yes	2X No	1 Yes	2 No	
/ita	ician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:				ce of Death	(Check anly a	ne)			
£	Physician: r this certific ral director,	၉	TLI Yes 20 No	10 Inpatient 2L	ER/Outpatier	K 3LI DOA				dence 6 🗆 C		ify)	
	g = e	on:	27. Manner of Death  ∑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	l W			d. Describe r	now injury occ	urred		
sio	Attending it death. ector: After by the fune	2 Accident investigation 2 Accident investigation 3 Suicide 6 Could not be 38 Place of Injury At home farm street feature of time.							3				
Division	al or Attendii s after death. al Director: A ed in by the fu	Certification:	4 Homicide determined	28e. Place of Injury - At I building, etc. (Spec	reet, factory, offic	t, factory, office 28f. Location ( City or To			(Street and Number or Rural Route Number, own, State)				
	urs a arai E		N-/	Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, a									
	To the Hospital within 24 hours a To the Funeral completely filled	Medical	29a. Certifier (Check only one) Certifying Physical Examone)	iner: On the basis of examin and manner stated.	iowiedge, deat ation and/or in	h occurred at the vestigation, in my	time, date a opinion, de	and place, an eath occurred	d at the time,	cause(s) and i date and place	nanner as e, and due	stated. to the cause(s)	
	To the within 2 To the complex	₩ We	29b. Signature and title of certifier	na		29c. Lice	nse number	number 29d.			. Date signed (Month, Day, Year)		
	⊢≱⊢ŏ		Dein n	Padelles D		NO	06.2	46	7_	2/6	100		
			20 Name and address of parent into	completed cause of death (Ite	om 23a) (Turas	Print)	6	100		210	16		
0	HVA		30. Name and address of person who co	An IMC C		ton D	Rive	C. 10	nhoni	ann	. M	D 21502	
7	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Sign	, ,	. , = , = , =		<u> </u>	, , , , ,	حسار ته وسميت			
(A)	Registr			2006	A. A	Ineral )							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🕕 🖟 💍 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** February 2006 3:08 a 25 Dorothy E. Plitt /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Ctr **Examiner** Carroll Lutheran Village Health Care Carroll Westminster If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days 1 ☐ M 2 🔀 F 217-05-5850 Director July 17 MD 96 Usual Residence of Decedent within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits if itam 27 is marked other than "naturel", or itams 23a or 28a-1 show or other traumatic event, the Medical Exeminer: wat be inclifted at 1 XYes 2 ☐ No Westminster MD Carroll Funeral Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 300 St. Luke Circle 21158 Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No White Specify. If Yes, Give Year or Dates: Specify: þ 3 Noticed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 1 and 2 should be filed withi Health and Mental Hygiene. Homemaker Own Home 8 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Emma Pickering William Weaver 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2895 Lady Esther Way Finksburg, MD Donald Plitt/son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Important: If ital
any injury or ott 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 NOther (Specify) Entombment Brooklyn, MD 2/28/2006 Cedar Hill Cemetery 22. Name and Address of Facility
Pritts Funeral Home and Chapel, P.A. 21. Signature of Funeral Service Licensee 21157 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, stich as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical to (or as a conseque **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed attending physicien and for use as the burial-tran Due to (or as a consequence of): Completed by Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 menths? 1 □ Yes 2 No Month Year 5 ☐ Other (specify) 4 Pregnant at time of death the 9 Unknown 9 Unknown signed by the 23e. Did tobacco use contribute to the cause of death? Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. No 3 Probably 4 Unknown 20 1 ☐ Yes peen Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performe certificate 1 Yes 1 TYes 25. Was case referred to medical examiner? director Be 26. Place of Death (Check only one, 2 No Hospital: Other: 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Medical Certification; To this Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After To the Hospital or Attanding Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu investigation 2 Accident 6 Could not be determined 3 🗍 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a, Certifier 1 🖰 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Montyl, Day, Year)

WIL

Maryland 21215-0036

Baltimore,

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Records,

of Vital

State Registrar 24

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

ORIGINAL

(parti

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

8 2005

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32. Registrar's Signature